Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1235 am Tune **Physician** imothu 2006 /Medical 4c. County of Death cility Name (If not institution, give street and number 4b, City, Town, or Location of Death Examiner lam General 9. Birthplace (State or Foreign Country) 6. Sex 1 M 2 ☐ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) urs. last birthday **Funeral** Hours Yrs. mare Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b. County 10c. City, Town or Location 10a. State Worle traumatic event, the Medical Examinar must be notified at Yes 2 No Completed by Funeral Director or Items 23s or 28s-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 462 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No a Specify: Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) upholsterer I Hygiene. College (1-4or 5+) OH OLSTERES NIA 18. Mother's Name (First, Middle, Maiden Sumame). 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fit thent of Health and Mental Heart: If item 27 is marked ot jury or other traumatic ever aurence 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Are, Bacto, md. Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Dispostion 3 Pemoval from State 1 ☐ Burial 2 € Cremation permit. Page Department of Important: If eny injury or once. 5 ☐ Other (Specify) 4 Donation 21. Signatur of Fineral Service is Home Balto, md (Jares P. ma 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) epsis **Physician** /Medical Due to (or as a consequence of): mmunadeficiency Syndrome Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner physicien and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical use as the igned by the ettending be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 4 Donknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an 2 No 1 🗌 Yes 20 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 DNatural 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral After 1 Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) determined 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier NWACHUKURU, MD 30. Name and address of person who combleted cause of death (Item 23a) (Fxpe, Print) Kenna

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

06-03717								lelible Ink					
Oumar Bah			State	of Maryland	•			nd Mental	Hygiene		9.0	0.0	1750
		1- For State Registrar			Cer	tificate o	f Death			Reg No	20	00	1750
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Medical Exami	ner	Oumar		Abdo	ulave		Bah		Month May 31,	2006	Year	155	5 hrs
A		4a Facility Name (if not institu	tion, give				4b. City, Town,	or Location of De	ath	40	County of D	eath	
·		Good Samaritan Ho	spital				Baltimore	City					
Funeral	╗	5. Social Security Number	6. Se	x 7.7	Age (In yrs. la	st birthday)	If Under 1 Ye	ear If Under 24	Hrs. 8. Date of	Birth (MM/	/DD/YYYY) 9.		
Director		620-08-3226	17	M 2 F	28	Yn	Months Da	ays Hours M	<sup>vlin.</sup> 12	02	77	reign Country)	West Africa
	-	Usual Residence of Decedent			20					<u> </u>			ALLICA
any	ı	10a State 10b. Coun	ty		10c. City.	Town or Loca	tion					10d Ins	ide City Limits
<b>*</b>		MD Mon	+ 0 01	nery		Silv	er Spr	ina				1 Y	es 2 X No
rylan ia-f s	용	MD   Mon 10e. Street and Number	Lgoi	шегу	-	DIIV	10f. Zip Code			10g Citi	zen of What (	Country?	
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hou:	eted	Elementary/Secondary (0-1		College (1-4 o				fe. DO NOT use		100.1	TAITE OF BUSINE	.somiadsiry	
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5-0036 led within 7 Hygiene other than	Comple	17. Father's Name (First, Midd	le Last)	JYLD			D D L L V		me (First, Middle	1			
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212 uld be Ments mark	P P	19a. Informant's Name/Relation				19b. Mailin	a Address (Str	eet and Number		umber C	ity or Town S	tate Zin Code	9)
MD 2 id 2 shou lith and 2 in 27 is r	-1	Fousseyni D			er			r Chase					"
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Departmen of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	-	20a. Method of Disposition		9 22 0 0 1 1			sition (Name of c		Date		Location - City		ate
Baltimore, permit. Pages I an Department of Hea Important: If iter		1 X Burial 2 Cremat	ion 3	Removal from	State C	rematory or o	ther place)						
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Physician /Medical		23a Part I Enter the disease, failure. List only one cau			ed the death	Do not enter	ne mode of dyin	g, suci i as cardia	ic or respiratory a	arrest, sno	ock, or near		umate Interval en Onset and
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Box 68760, death certificate be the attending physic of for use as the burden b	sician/Me	IF FEMALE:	tho	23c. If yes, outo		ancy				230	d. Date of deli	very	
68 ertifi ding	an	23b. Was decedent pregnant in past 12 months?	i trie	1 Live birth	at time of dea		etal death 3	Ectopic pre	gnancy		Month	Day	Year
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Division ppital or Attencours after death terral Director:	er	Odicide	termined		ocal Stree	t			7000 blk o		ean Blvd.,	Baltimore	City , MD
Divisior Hospital or Attend 24 hours after death Futteral Director:	2	29a Certifier	Physici	an: To the best of	my knowledg	e, death occu	rred at the time,	date and place, a	and due to the ca	iuse(s) an	nd manner as :	started.	
Division of Vital Records, P.O. Box 68760, within 24 lospital or Attending Physician: The law requires that the death certificate be within 24 lours after death.  To the Futureral Director: After this certificate has been signed by the attending physic completely filled in by the futureral director, page 2 should be detached for use as the bur	Medical		xaminer	On the basis of e		nd/or investiga	ition, in my opini	on, death occurre	ed at the time, da	te and pla	ace, and due t	o the cause(s	)
F iv i	Be	29b. Signature and title of cert	ifier	and manner state	<u> </u>		29c. Licer	nse number		29d	Date signed (	Month, Day,\	'ear)
		(a sint	/	LA 1	() (M	11	0.0	C.M.E.		Jun	e 1, 2006		
7		30. Name and address of pers	on who	nompleted cause of	of death (Item	23a)				1			
10	Į			nt Medical Ex			Street, Baltir	more, MD 212	201				
	ate	31. Date filed (Month, Day, Yes		.7	trar's Sonatu	-	)						
Regist			006	BERENE		The same of							
		-		R									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Month Day **Physician** 2006 May 30 23:20 Booth /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 VA 5. Social Security Number **Funeral** 1 □ M 2 🛛 F 217-14-1919 96 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ▼ No Baltimore Hunt Valley Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or U.S.A. 21030 708 Nicholas Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 X No Specify: þ Specify: Black 3¥ Widowed 4 □ Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sinai Hospital Dietary Assistant 12th grade na other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill timent of Health and Mental H tent: If Itam 27 le marked ott jury or other traumatic ever Be Fannie Green Edward Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Camilla B. Peterson-Daughter 708 Nicholas Lane, Hunt Valley, Md 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Murial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If any Injury or once. 6/5/06 Arbutus, Md 4 □ Donation 5 □ Other (Specify) Arbutus Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West aret 4300 Wabash Ave, Baltimore, 21215 234 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Stage end /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) been signed by the attending physicien and should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 ☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? this certificate has ral director, page 2 autopsy performed 1 ☐ Yes 2 ☐ No 1□ Yes 2 No : After this certification at the state of t Be 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence Other (Specify) Hospital: 1 Yes 2 No ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1-Natural 5 Pending To the Hoepital or Attendir within 24 hours after death. To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier Contriving Physician. To the best of ...y knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29h. Signature and title of certified 29d. Date signed (Month, Day, Year) completed cause of death (Item 20a) Type, Print) 30. Name and address of N. Charles St. Balto Md sonc 6701 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006

06-03636 Charles Burrell

# Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene

2006 17504

1- For State Certificate of Death Reg. No Registrar 2 Date of Death Time of Death Decedent's Name (First, Middle,Last) Physician/ Month Day May 28, 2006 2135 hrs **Medical Examiner** Burrell William Charles 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4801 West Forrest Park Avenue **Baltimore City** 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Months Davs Hours MD Director 01 19 58 Country) 48 X XM 2 213-72-7488 Usual Residence of Decedent 10d Inside City Limits 10c City, Town or Location any 1 X Yes 2 No Baltimore NA or items 23a or 28a-f show must be notified at once. MD Director 10g Citizen of What Country? 10f Zip Code 10e. Street and Number U.S.A. 21207 4801 West Forest Park Ave 14 Race - American Indian Black 13 Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S Funeral 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 Never Married 2 X Married Yes Black 0 f Yes. Give Year Yes 2 X No specify. Specify Widowed Divorced "natural", Examiner 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Completed Y and L College (1-4 or 5+) Elementary/Secondary (0-12) nit Pages I and 2 should be filed within 72 Partment of Health and Mental Hygiene.

portant: If item 27 is marked other than "r

rry or other traumatic event, the Medical E Bus Aid Baltimore, MD 21215-0036 Transportation na 12th grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elethia Thomas William Kenneth Burrell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 4801 West Forest Park Ave, Balto, Md 21207 Kimberly Burrell-Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery crematory or other place) Date 20a Method of Disposition Burial 2 X Cremation 3 Removal from State 6/1/06 Baltimore, Md Donation 5 Other Specify Metro Crematory 22 Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21. Semature of Funeral Service Licensee 10 m DRUN 21207 1 me t I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure List only one cause on each line /Medical Death Immediate Cause (Final disease a Hypertensive cardiovascular disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last executed and Physician/Medical item#23a,27,perME,g856,6/12/06 TT physician : X UNPENDED AMENDED Box 68760. IF FEMALE. 23c. If yes, outcome of pregnancy 23b Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Month Day Year Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ó þ 1 Yes 2 No 3 Probably 4 V Unknown σ. Completed Division of Vital Records, 24a Was an 24b. Were autopsy findings available certificate has been prior to completion of cause of autopsy performed? death? Yes Yes 2 V No 26.Place of Death (Check only one) the Hospital or Attending Physician: hin 24 hours after death. 25 Was case referred to medical Be Other<sub>4</sub> examiner? Hospital: 1 Inpatient DOA Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 After this 1 🗸 Yes ٩ 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 1 X Natural Yes 2 No 5 Pending within 24 hours after death To the Funeral Director: Investigation 2 Accident 28e Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide or Town, State) determined 4 Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie May 29, 2006 OCME 201 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore King MD. 31. Date filed (Month, Day, Year) JUN 0 5 strar's Signature State 2008 Registrar

ORIGINAL

06-03468 Inez Yvette Coley

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 17505

		1- For State Registrar		Certific	ate of	Death_				Reg. No.	200		100
Physicia ledical Exami	ner	1. Decedent's Name (First, Mic	Yvette			oley			2. Date of De Month May 22,	Day 2006	Year	3. Time of 1048	
1		4a, Facility Name (if not institu	tion, give street and number)	)	41	D. City, Town		ation of De	ath	4c. C	ounty of Deat		
Funeral		5. Social Security Number	6. Sex 7. Ag	je (In yrs last bir	thday)	If Under 1	Year If	Under 24I	_	Birth (MM/DD	/YYYY) 9 Bi	rthplace (Sta	ite or
Director		220-80-2104	1 M 2 XF	45	Yrs	Months (	Days	Hours N	<sup>vlin.</sup> 11–08	3-1960	Forei		Md.
*		Usual Residence of Decedent 10a, State 10b Count		10c. City, Town	or Locatio							10d Inside	e City Limits
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Maryland 28a-f show 1 at once.	cto	10e. Street and Number	1471	1	Jaran	10f. Zip Coo	de			10g Citizer	of What Cou		
the Ma 1 or 28	Director	434 Watty	Ct.			21	201				USA		
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiewith hand "natural", or items 23a or 28arf she matic event, the Medical Examiner must be notified at once	uneral	11 Marital Status	12. Was Decedent						(Specify Yes or Nerto Rican, etc.)	lo- 14	Race - Ame White, etc	rican Indian,	Black,
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J036 within 72 hours afterene er than "natural", Medical Examiner	Completed	Elementary/Secondary (0-1	2) College (1-4 or	5+)		st of working		NOT use	retired)				
5-0036 led within 72 Hygiene other than the Medical	duc	11th grade  17. Father's Name (First, Midd	la Lasi		Do	mestic		Anther's Na	ame (First, Middle		her Pe	eople	Homes
215-00 be filed wit ntal Hygien rked other ent, the M	ادة	Willie	ie, Last)	Coley			10.10	Inez		, Walder ou		vis	
ID 21215-00; should be filed with and Mental Hygiene 77 is marked other timatic event, the Med	To B	19a Informant's Name/Relatio		198		, ,	_		or Rural Route N				
- P# E R		Thomas Jay  20a. Method of Disposition	Peacher, Sr			I Oxio			2nd Fl.		imore,		21201
more, M Pages 1 and 2 ient of Health int: If item 2		and the second second	ion 3 Removal from St	tate crema	tory or oth	er place)					-		
		4 Donation 5 Other 21. Signature of Funeral Servi	Specify:	Mt.		mel Co			5-1-06 F		undalk re,Md		
Balti permit Departm Imports		trune	- / See		_	1arch					North		differential and
Physician		23a. Part I Enter the disease, failure. List only one cau	or complications that causes	the death. Do n	ot enter th	e mode of dy	ving, suc	h as cardia	ac or respiratory a	rrest, shock	, or heart		nate Interval n Onset and
/Medical Examiner		Immediate Cause (Final disea	se a Chronic ren		e							1	Death
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760, cate be execut physician and he burial - trai	n/Medical	X UNPENDED	X AMENDED ite	m#4a,23a, em#4a.pen	在, per 12.885	1 <sup>ME</sup> , 285/ 7 , 7/13/(	冷堆	2/06 TI		224 (	Date of delive		
18760, rtificate be ing physic as the bur	M/M	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	23c. If yes, outco	ime of pregnancy		al death	3	Ectopic pre	gnancy		onth	Day	Year
Box 6 e death cert the attendi	sicia	1 Yes 2 No 9 🗸		t time of death	5 Oth	er (Specify)							
	Phy	Part II. Other significant con		th but not resulting	ng in the u	nderlying cau	use givei	n in Part I	23e. Dio	tobacco us	e contribute to	the cause	of death?
P.O. res that the signed by be detach	d by								_ 1 _ 1	'es 2 N	No 3 Pro	obably 4	Unknown
ords, w requir s been s should	ompleted									opsy	prior to	utopsy findir completion	ngs available of cause of
Reco The law icate has	mo									formed?	death?	es 2	No
Vital F ysician: his certifi	Be C	25. Was case referred to med examiner?	I I a a set al				Oth		eck only one)		ه ۲۰۰		
Division of Vital Records, tal or Attending Physician: The law requinant and after death and abrector. After this certificate has been seled in by the funeral director, page 2 should I	은	1 Yes 2 No 27. Manner of Death	28a Date of In	jury 28b.	Outpatient Time of Ir		Injury a		28d Describ		e 6 🗸 Othe	er Scene	
ion of V tending Phy eath tor: After the	tion	1 X Natural 5 P	(Month, Day ending	Year)		1	Yes	2 No					
ViSion Attender de Directo	ifica		ould not be 28e. Place of I	Injury - At home,	farm, stree	t, factory, off	fice build	ling, etc.	28f. Location or Town		Number or R	tural Route N	lumber, City
Divi spital or nours afte ueral Dir	Certification:	4 Homicide	etermined (Specify)										
Division  To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the			Physician: To the best of rexaminer:On the basis of ex										
To To Com	Medical	29b. Signature and title of cer	and manner stated	1		29c. Li	cense n	umber		29d Da	ite signed (M	onth, Day, Ye	ear)
· A-		11 John	Com.			0	C.M.I	E.		May 2	23, 2006		
19		30. Name and address of per-											
7		Laron Locke MD.	Assistant Medical Ex		11 Penn	Street, B	altimo	re, MD 2	21201			_	
S Regis	tate trai	11	2006	rar's Signature	Same								
	_			-									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Month Physician 2:15A June 1, 2006 ROBERT WILLIAM CULP /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Greater Baltimore Medical Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. April 26, 1924 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Mary land XX M 2 F 217-18-8167 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinal must be notified at 28a-f show XXYes 2□No N/A Baltimore Directo Maryland 10g. Citizen of What Country? 10e, Street and Number 10f. Zio Code USA 21212 211 Hollen Road death 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 □ No WWII If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Menta! Hygiene. Important: If item 27 is marked other than "natural", or iter sny injury or other traumatic event, the Medical Examinal once. 1 Never Married 2 Married 1 ☐ Yes XX No Specify: Saltimore, Maryland 21215-0036 White Specify: ρ XX Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Jeweler Jewelrv 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Marie Hampson Culp William James Holland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 211 Hollen Rd Baltimore, Maryland 21212 Dtr Phyllis K Ward 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Wurial 2 ☐ Cremation 3 ☐ Removal from State Timonium Maryland Donation 5 Other (Specify) Dulaney Valley Mem Gardens | 6/5/06 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 21/ Fignature of Funeral/Service Licens 6500 York Road Baltimore Maryland 21212 Innis Approximate 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ardran /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown 9 Unknown has been signed to 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 2 No certificate 1 ☐ Yes or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death | Check only one) examiner Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: ို 1 Yes 2 No 1 VInpatient 2 ER/Outpatient 3 DOA After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) δ 4 - Homicide within 24 hours a To the Funerei f 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certition un Opp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 JUN 0 5 31. Date filed (Month, State 2006 South Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Stems 9.15.16a per fine 856.6-5-06 wt.

State of Maryland Penarmen of Health and Wental Hygiene of Communications.

			Amend items 9.15.16a State of Maryland	Department of He	aith and Me	ental Hygi	ene nns	17507
		1	1 - State Registrar	Certificate of D	eath	Re	g. No.	, 7001
			1. Decedent's Name (First, Middle, Last)		2	2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic	al -	Joyce Ann Clark			June $1$ ,	2006	9:40 P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Lo	ocation of Death erick		4c. County of Dea	
26	Maria de la compansión de	¥.	1421 Taney Avenue, Apt. 131  5. Social Security Number 6. Sex 7. Age (In yrs. last			B. Date of Birthy (Month, Day)		ederick thplace (State or Foreign
	Funeral Director		213-46-3376 10M 254F COC	Yrs. Months Days	Hours Min.	Month, Day	Year)	MD.
	g		Usual Residence of Decedent					10d. Inside City Limits
	anylan show d at	<u></u>	10a. State 10b. County 10c. City, T	own or Location				1 Wes 2 No
	8a-f	ecto	10e, Street and Number	COCTIC S		10	g. Citizen of What C	ountry?
	a or	ă	100. Street and relimber	31	702		115	
	72 hours after death with the Maryland natural', or Items 23s or 28s-f show digal Examilian must be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hisp	panic Origin? (Spec	ofy Yes or No-	14. Race - Am	
9	or Iter	F.	1 Never Married 2 Married I 1 Yes 2 No If Yes, Give	If Yes, specify Cuban, 1 ☐ Yes 2 ☑ No	Specify:	ican, etc.)	Black, Whi	1/ D
21215-0036	ural', c	Completed by	3 Widowed 4 Divorced Year or Dates:	/			1	nece
2-0	natu	ete	15. Decedent's Education (Specify only highest grade completed)	<ol> <li>Decedent's Usual Occupati (Give kind of work done du life. DONOT STREED)</li> </ol>	ring most of working	9	6b. Kind of Business	/industry
121	within ene. than	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	Acab	ecl		Healthca:	re
	Hygin Other ent, I		17. Father's Name (First, Middle, Last)	1	18. Mother's Name	(First, Middle, M	laiden Sumame)	
lan	lid be rked c	To Be	Woodrow Dawson		Sadi	e Turne	r	
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If Item 27 Is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event, the Medical Examinational Lancollified at	-	19a. Informanl's Name/Relationship (Type, Print)	19b. Mailing Address (Street an	nd Number or Rural	Route Number,	City or Town, State,	Zip Code)
	and 2 ealth n 27 I		Brenda Fowler/Sister	8108 Clearfie				
ore	Pages 1 nent of He int: If Iter iry or oth		1 Burial 2 N Cremation 3 Removal from State	e of Disposition (Name of etery, crematory or other place)	)		20c. Location - City o	
Ë	Pag tment tant:		4 □Donation 5 □Other (Specify) Metro	o Crematory, I	nc. 6/3/0		Baltimor	
Baltimore,	permit. Pages t are Department of Heal Important: If Item eny injury or othe pince.		21. Signature of Edward A. Gregorchik	22. Name and Address 299 Frede				
H			23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.	Do not enler the mode of dying,	, such as cardiac or	respiratory rre	est,	Approximate Interval Between
V	Physician		Immediate Cause (Final disease or condition	Time hoe	ent 1	aill	1 - 0	Onset and Death
	/Medical		resulting in death)	ice of):	a m A			
B	Examiner	_	Sequentially list conditions, b. Due to (or as a consequence)	alaxl.	CUP		7.7	
7	ed self	Examine	cause. Enter Underlying Cause (Disease or injury	CG OI).	HT	1/		
	xecut and al-trar	xan	that initiated events c. Due to (or as a consequer	ice of):	+1 1 /			
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	cai	d					
9	tificat ng phy as th							
Box	eath certific attending p I for use as i	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal de				23d. Date of d Month	elivery Day Year
	e dea	sici	in the past 12 months?  1 □ Yes 2 No 4 □ Pregnant at time of deat 9 □ Unknown 9 □ Unknown	h 5 Other (specify)			17.51111	Su, Vol.
P.0	that the de led by the detached		Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause giver	n in Part I.	23e. Did tob	acco use contribute	lo the cause of death?
ds,	signe d be c	d by	and the state of t	· · · · · · · · · · · · · · · · · · ·		1 X Ye	s 2 No 3 I	Probably 4 Unknown
Records,	require been si should t	Completed				24a. Was a	n 24b. Were a	autopsy findings available
Re	The lav	E D				autops	ned death?	completion of cause of
Vital		0	25. Was case referred to medical		26. Place of Death	Name of the Park		55 2 100
Ž	ys dill	ToB	examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 EF	VOutpatient 3□ DOA Dther	r. 4 Nursing Hon	ne 5 Meside	nce 6 Other (Sp	ecify)
n of	ding Ph h. After th funeral		27. Manger of Death 28a. Date of Injury 28a. Date of Injury (Month, Day Year)	Bb. Time of 28c. Injury Work?	?	8d. Describe ho	w injury occurred	
Siol		catio	2 Accident investigation		es 2 No	D		3 / S
Division	after d Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hombuilding, etc. (Specify)	e, farm, street, factory, office	2	City or Town	reet and Number or I n, State)	Hurar Houte Number,
	pltal ours a eral (		29a. Certifier 1 Certifying Physician: To the best of my knowle	edge, death occurred at the time	e, date and place, a	and due to the ca	ause(s) and manner	as stated.
	To the Hospital or Attenwithin 24 hours after deal To the Funeral Director: completely filled in by the	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or investigation, in my opi	inion, death occurre	ed at the time, d	ate and place, and d	ue to the cause(s)
	To th To th	₹	29b. Signature and title of certifier	29c. License	number	2	9d. Date signed (Mo.	nth, Day, Year)
			Millian K Canson	1 020	395		June 2, 2	2006
	10		V	3a) (Type, Print)				
	10			omas Johnson D	rive, Fre	ederick,	MD 2170	2
3	St Regist	ate	31. Date filed (Month, Day, Year)  32 Registrar's Signatur  JUN 0 5 2006	house				
4	negisi	तथा	JUN 0 3 ZUUD JOSES JO	Marie Contraction of the Contrac				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#17, perFH, 0856/ 6/5/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Chandler Sr. May 26 2006 4:30 a Allen Keith /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7202 Brompton Road Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 07 14 59 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Months X M 2 □ F 46 Yrs. Director PA 178-52-1254 Usual Residence of Decedent the Maryland 10h County 10a State 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director 1XXYes 2 □ No NA Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 7202 Brompton Road 21207 Items 23a U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "neturel", or 1 Yes 2 No Specify: ፩ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be lifted w Department of Health and Mental Hygien Important: If item 27 is marked other th. eny injury or other traumatic event, Ling. 2002. 12th grade lyr Driver J.J. Haines Co. 17. Father's Name (First, Middle, Last) Chandler 18. Mother's Name (First, Middle, Maiden Sumame) Be Rose Poulson Chanlder 2 James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7202 Brompton Road, Baltimore, Md 21207 Marsha <del>Chandler</del>-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 6/5/06 Owings Mills, Md Garrison Forest 21. Signalurato Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Pa /1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final diseate or condition resulting in death) Physician ARTERY disease WROHARY week /Medical Due to (or as a cons quence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of). Box 68760 physiclen Physician/Medical esn. IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No s certificete hes been signed by the atte lirector, page 2 should be detached for Day Year 5 Other (specify) P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 [Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural s effer de. 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 TAccident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medicai completely 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ŝ 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) 40059780 2/20/2006 100 D who completed cause of death (Item 23a) (Type, Print) Suite soo Baltimore MD DAWN YERSHWER 5+ 3333 N. Calvert 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Jr Dukes 01 ouic 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimor

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day)

Months Days Hours Min. Dac 19 HOSPI ta altimore 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 217-24-1971 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla nand to Heelth and Mantel Hyglene.

and it if item 72 is marked other than "natural", or itema 23a or 28a-1 ahov ury or othar traumatic avant, ite Macitel Examinatic must be notified at Baltimore Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Are 21239 40twolliw USA 5809 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1□Yes a□ No Specify: Black Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Good Samaritar Elementary/Secondary (0-12) College (1-4or 5+) Maintenance 10+h Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Woods Lunes ٩ LOUIR 19a. Informant's Name/Relationship (Type) Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5809 Willowton Ave Baltimore Nd Lorraine 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o f Burial 2 ☐ Cremation 3 ☐ Removal from State 9 Garrison Forest VA Clem 106 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chaman - Harris 21. Signature of Funeral Service Licensee 5240 Relateratown Rd Baltimore Harry 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition NON-Hodakins Lymphoma Physician 20 year resulting in death) /Medical Due to (or as a consequence of) Examiner andiomy O Day Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, ≅ Due to (or as a consequence of) attending physiclen for use as the buria Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate hes b irector, page 2 s 1 ☐ Yes 2 ☐ No 1 Yes No 25. Was case referred to medical examiner? funeral director 26. Place of Death | Check only one Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After t Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural Accident Injury 5 Pending within 24 hours efter death.

To the Funarei Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and totle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEPARTMENT MANJULA GUNAWARDANE Greene 22 ST. BALTIMORE MP 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Michael S. Dailey

06-03576 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day May 27, 2006 Michael S. Dailey 0735 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** 1600 Northwick Road NΑ If Under 1 Year If Under 24Hrs 8. Date of Birth(MM/DD/YYYY 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 9 Birthplace (State or **Funeral** Foreign Months Days Hours Min Director 1**XX**M 2 Country) 217-54-2200 56 11-24-1949 Yrs Md. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Md. NA Baltimore XYes 2 No s 23a or 28a-f show e notified at once. 28a-f show I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiest and Arabid and Arabid and I simmarked to the arabid and a standard of the I should be a standard to the Arabid and a standard the Medical Examiner must be notified at once transmatite event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country USA 21218 1600 Northwick Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14 Race - American Indian, Black White, etc. Armed Forces? 2 Never Married Married Yes Black If Yes, Give Year 1 Yes 2 X No specify Specify ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 12th grade Retail Clerk Whole Foods 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Britton Margaret Be Maceo Dailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2121 N. Patterson PK., Baltimore, Md. 1219 Melvin Dailev Brother Baltimore, N permit. Pages I and Department of Health Important: If item injury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State crematory or other place) 2 Cremation 3 Removal from State 6-5-06 Dundalk, Md. Carmel Cem. Donation 5 Other Specify: 22. Name and Address of Facility Baltimore, Md. 21202 21. Signature of Funeral Service Licenses March F.H. East 1101 E. North Ave. 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Narcotic intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical AMENDED item#23a,27,28a-f,perME,g856, 6/8/06 TT X UNPENDED attending physician or use as the burial Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23b Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown by the signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death
To the Funeral Director: After this certificate has been signed by 9 ğ Yes 2 ✓ No 3 Probably 4 Unknown Completed After this certificate has been sameral director, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medica Be examiner? Hospital: 1 Inpatient 2 Other<sub>4</sub> ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 V Yes 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 1 Yes 2X No unk 5 Pending Fnd 5/27/2006 d in by the f Fnd 7:20 am 28f. Location (Street and Number of Rural Route Number, City of Town, State) 1600 Nor LTWICK, Rd 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be Baltimore, MD Suicide determined (Specify) found at residence Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d Date signed (Month, Day, Year) 29b. Signature and title of certif 29c. License numbei May 27, 2006 O.C.M.E. o completed cause f death (Item 23a) 30. Name and a dres of person Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Mo Day Year) State Registrar

32. Registrar's Signature

2006

ORIGINAL

		_	1 - For State Registrar	State of Maryland /		artment of H rtificate of L			giene 2 () Reg. No.	06	17511
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	/Medic	cal	Mary Ellen Dow					May		<u>ბზ</u> 6	3:30A M
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	uneral		5. Social Security Number 6. Se		rthday)	Edgewat	If Under 2		h	9. Birthp	lace (State or Foreign
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30 after	P E	by Fu	Never Married 2 Married	1 ☐ Yes 2 📉 No If Yes, Give		I ☐ Yes 2X No	Specify:	, dollo modif, etc.)	Specify	k, White,	ack
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be filed	doth	Be	17. Father's Name (First, Middle, Last)					s Name (First, Middle,	Maiden Sumam	е)	
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Mar d 2 sh	7 Is n traun		19a. Informant's Name/Relationship (T) Tonia Greenfie!					or Rural Route Number Edgewate			Code) 037
a - 4	tem 2 other		20a. Method of Disposition			sition (Name of		Date	20c. Location -		
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	2 6 0		23a. Part1. Enter the disease, or comp	lications that caused the death. Do		·		Annapolis		214	
			shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.		132	700	97W 10	SEC		Approximate Interval Between Onset and Death
	sician edical		disease or condition resulting in death)	a. Acute Halma Due to (or as a consequence	-	nagre le	renvo	Vascular	Heciden	7	
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death	e atte	icia	in the past 12 menths?	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death		Ectopic pregnancy Other <i>(specify)</i>			Mon	nth	Day Year
at the C	by the	Phys	9 Unknown	9□ Unknown							
The law requires that the	be d	þ	Part II. Other significant conditions co	ntributing to death but not resulting i	n the ur	iderlying cause give	n in Part I.				e cause of death?
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or Att	Direct in by	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, to building, etc. (Specify)	arm, stre	eet, factory, office		28f. Location (S City or Tow	treet and Numbe n, State)	er or Rural	Route Number,
Hospital or 24 hours afte	To the Funerel Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medicel Exem	sician: To the best of my knowledge iner: On the basis of examination ar	e, death	occurred at the time	e, date and	place, and due to the o	ause(s) and mar	ner as sta	ated.
he t	mplet	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. License			9d. Date signed		
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0	1		30. Name and address of person who o	ompleted cause of death (Item 22a)	(Type !	2,50			-		
7			5851 - Deale	e Church tov	(, )ha';	ROOM	17-0	ODIA V	ND S	075	51
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	Ana	de)		- 4/	7 / p		
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	Physicia		1. Decedent's Name (First, Middle, Last)	ER	501		2. Date of Death Month	Day 2006	3. Time of Death  3: 43 AM
	/Medic Examin		4a. Facility Name (If not institution, give street and number	r)	4b. City, Town, or L	ocation of Death		4c. County of Deat	h
	_,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Howard County General Hosp	oital	Columbi	.a		Howa	rd
	Funeral		5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Yeer)   Co	hplace (State or Foreign ountry)
	Director		213-28-8683	75 Yrs.			JAN 25,	1931	Maryland
	and *	1	Usual Residence of Decedent  10a, State 10b, County	10c. City, Town or Lo	ocation				10d. Inside City Limits
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	28a-	rect	10e. Street and Number		10f. Zip Code	L CILY	10	g. Citizen of What Co	ountry?
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Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23s or 28s-f show ant, the Medical Evantral must be inclified at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupat a kind of work done du DO NOT use retired)	ion rring most of work		6b. Kind of Business	•
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an	o d tal	o Be	William H. Eason			Ar	na Korte	<u> </u>	
<u></u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Mexical Examinat must be useful at any injury or other traumatic event, the Mexical Examinat must be useful at ances.	은	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ing Address (Street ar	nd Number or Rur	al Route Number,	City or Town, State,	Zip Code)
	and 2 ealth a n 27 ls		Nancy Lee Eason/Wife	1010	06 Century	Drive	Elliott	City, MD	21042
ē,	the standard of the standard o		20a. Method of Disposition	20b. Place of Dispo cemetery, crei	osition (Name of ematory or other place,	)	Date 2	20c. Location - City or	Town, State
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m	20 5 5 8		Edward A. Gregorchik	ill.	301 Freder	ick Road	Catons	ville, MD	21228
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<u>≥</u>	after Dirac	Certification:	4 Homicide determined 206. Flace of building,	etc. (Specify)	7,		City or Town	, State)	
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	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Regi	strar's Signature	and .				

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

			I- For State Registrar	Cer	tificate of L	Death			Red	g. No.	200	6 1/51
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	32/		4a. Facility Name (if not institution, given 827 Arlington Avenue #1)	·	i i	. City, Town, or Baltimore	Location of	Death		4c. Co	unty of Death	
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	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces?		Decedent of His s, specify Cubar					White, etc.	an Indian, Black,
	ter de:		3 X Widowed 4 Divorce	1 Yes 2 X No	1 ,	res 2 X No	specify:			Spe	ecify:	Black
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	alti rmit. spartm sports jury o	1	T. Signature of Funeral Service Lice		22. Na	me and Address	s of Facility	+	· ·			
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	68760 certificate b rding physics se as the bu	≩	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg		al death 3	Ectopic	pregnancy			ate of delivery onth D	lay Year
	Box 687 ne death certific the attending	Physician	past 12 months?	4 Pregnant at time of	-	er (Specify)	Lotopio	programo,		110		.,
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	anding th r: Af	ţi	1 Natural 5 Pending	(Month, Day, Year)		1	Yes 2	No				
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1	2 1		30. Name and address of person who Laron Locke MD. Assi	o completed cause of death (Iter stant Medical Examiner		Street, Baltii	more. M	D 21201				
_		tate		32. Registrar's Signal	-	AP E					-	
	Regis			100	18 6000	Care Contract						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#1, pently 2856,675,06 TI Department of Health and Mental Hygiene [] [] [ 1 - For State Registrar Certificate of Death Rea. No. 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 00 Eddie M. Greene /Medical 4b. City, Town, or Location of Death County of Death Facility Name (If not institution, give street and number) **Examiner** altimor 1 ecents em If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday)
Yrs. 5. Social Security Number **Funeral** Months 10 M 2 F Days Hours Min. 218-80-4123 Mar. 28 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County worle rthen "natural", or items 23a or 28a-f ehov the Medical Exeminer must by nutified at Md 1 Yes 2 □ No **Funeral Director** altimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3801 USA 2122 RIVE death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Home Improvement Elementary/Secondary (0-12) College (1-4or 5+) 9+h Laborer permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked other any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unhnown Mae 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3801 Md 21229 Gelston T Baltimore aunt rields 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Creenmount Cremator 5/27/06 Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Ffility Chatman-Harris Funzial Home 21. Signature of Mineral Service Licer 5240 Reisterstown Ad Baltimore Md 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between On*s*et and Death Immediate Cause (Final disease or condition resulting in death) e Dimonia **Physician** /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consecuence of) Examiner certificate be executed and Due to (or as a consequence of) burial-1 Division of Vital Records, P.O. Box 68760, physicien Physician/Medical thet use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month ģ in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) signed by the e 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospitel or Attending Physicien: within 24 hours after death.
To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient ٩ 1 🗌 Yes 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Dat - signed (Month, Day, Year) 29b. Signature and title of certifie 0060201 30. Name and addres of person who completed cause of death (Item 23a) (Type, Print) W. Baltimon Menatie 000 32. sistrar's Signature 31. Date filed (Month, Day, Year) State JUN 0 5 2006 Registrar

			1 - State Registrar	State of Marylar		ent of Health ate of Death		tal Hygiene Reg. No	2000	17515
			Decedent's Name (First, Middle, Last)				2.0	ate of Death		3. Time of Death
	Physici		George Berna	rd Gephar	dt Jr		7	Month Da	3 2006	6:52PM
	/Medic Examir		4a. Facility Name (If not institution, give s			City, Town, or Location	n of Death	45	County of Death	4
			Franklin Sau	are Hospit	al	Kosedo	918		miltir	nose
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		nder 1 Year   If Under this Days   Hours	er 24 Hrs. 8. D	ate of Birth Month, Day, Year,	9. Birth	place (State or Foreign
	Director		113 30 7730 A	M 2□F	74 Yrs. Will	uis Days Hours	Ju	ly 8,193		vland
	Du *		Usual Residence of Decedent  10a. State 10b. County	10c Ci	ty, Town or Location					10d. Inside City Limits
	eho eho	<b>5</b>	· ·							1 ☐ Yes 2 ☐ X o
	the N	Director	Maryland Baltimore		Rosedale	. Zip Code		10- 0	tizen of What Cou	
	death with the Maryland me 23a or 28a-f ehow Linual be notified at	គ	207 Potomac Avenue		10	21237				illy:
1	eath	by Funeral		12. Was Decedent Ever in U	IS 13 Was D		Origin? (Specify		JSA 14. Race - Ameri	can Indian
Q)	fter d	듄	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 ☐ No	If Yes,	ecedent of Hispanic C specify Cuban, Mexico	an, Puerto Ricar	n, etc.)	Black, White	
STO.	urs a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 1952	-60 1□Y	es 2 🗓 No Specifi	fy:		Specify: Whi	te
0	72 ho	Completed	15. Decedent's Edu			Usual Occupation f work done during mo	net of working	16b. i	Cind of Business/Ir	
-60 2121	thin 7	P P	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	T use retired)	ost or working			
7 2	ygien yer th	ပ္ပ	6		Heavy E	quipment C			_Landfil	.1
2 P	d oth	Be	17. Father's Name (First, Middle, Last)					st, Middle, Maidei		
<del>                                      </del>	ould Men Merke Marke	은	George B. Geph				egina	Laubac		
ephardt, Baltimore, Marylan	permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylan Deportment of Health and Mental Hygiene. Importent: if item 27 ie marked other then "naturel", or iteme 23a or 28a-1 ehow myn njury or other treumatic event, the Medical Examiliaci must be notified at anothe.		19a. Informant's Name/Relationship (Ty Martha Gephardt —			ress (Street and Num. OMAC AVENU				
E, 1	Healthealt 2		20a. Method of Disposition		Place of Disposition		Date		ocation - City or T	
و چ	ages if it		1 Burial 2 ☐ Cremation 3 ☐ F	emoval from State	cemetery, crematory inkwood Ce	or other place)				
a.	it. Pertant		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License			e and Address of Fac	June 62		timore M	_
D &	Dep Dep Impo	1	21. Signature of Fulleral Delvine Electrist				Br			l Home PA
0	_		23a. Part1. Enter the disease, or complish ck, or heart failure. List only or	ations that caused the dea		Old Easte			Marylan	d 21221 Approximate
				caus on each line.				,		Interval Between Onset and Death
	Physician /Medical		Immedia of ause (Final disease of ondition resulting in death)	Due to (or as a see see	ycem	na				
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8760	ate be ex hysicien the buria	dical		1.						
9	artifica ing pl	Med	IF FEMALE:							
Вох	eath certific attending p I for use as	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet	al death 3 ☐Ector	ic pregnancy			23d. Date of deliving Month	ery Day Year
0	it the dea by the a teched f	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of o	death 5 ☐ Othe	r (specify)			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Day
Division of Vital Records, P.O.	Attending Physicien: The law requires that the death certific deeth. sctor: After this certificate has been signed by the attending p by the funeral director, page 2 should be deteched for use as	든	Part II. Other significant conditions con	ntributing to death but not res	sulting in the underly	ing cause given in Par	+1	23e Did tobacco	use contribute to	the cause of death?
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Ö	w requir been si should	Completed								/\
Je G	he law has ge 2 s	ם						24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
<u>a</u>	iclan: The l certificete ha rector, page		05 W					1□ Yes 2 XX N	o 1 ☐ Yes	2 No
ž.	ysician: nis certific director,	Be C	25. Was case referred to medical examiner?  1 X Yes 2 No	lospital:	(FD/O	Other	ice of Death (Ch		- 50	
οţ	Phys r this aral di	2	1 X Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 3[ 28b. Time of	DOA 28c. Injury at Work?		5   Residence Describe how inju	6 ☐Other (Speci	fy)
on	nding Ph th. : After this	ş	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury M		□No		•	
Visi	el or Attendil efter deeth. I Director: A d in by the fu	150	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h	nome, farm, street, fa	ctory, office			nd Number or Rur	al Route Number.
á	s effe	Certification:	4   Hornicide	building, etc. (Speci	ny)		,	City or Town, Stat	θ)	
	e Hospitel or a 24 hours efter e Funeral Direction in letely filled in E	cal	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exemi	sician: To the best of my kn	owledge, death occu	rred at the time, date a	and place, and o	due to the cause(s	s) and manner as	stated.
	To the Hos within 24 h To the Fur completely	ledical	one)	and manner stated.	anon and/or investig					
	To Yelt	Σ	29b. Signature and title of certifier			29c. License number	1 7	29d. Da	ate signed (Month,	Day, Year)
	. ( )		Fond of	My My	/	11625	01	06	0-03	-06
(	5×1		30. Name and address of person who of	impleted cause of death (Ite	m 23a) (Type, Print)	Ç	the	0 - 11		M0, 21237
		010	31. Date filed (Month, Day, Year)	32. Registrar's Sign	CIN DIN	guale	VIIVE	= 1salt	imole 1	1110,2125/
	Regist	ate	JUN 0 5 2	006	The dog	87		•	•	

			1 = For State Registrar	State of M	larylan	•		nt of H <i>te of L</i>		ind Me		ene2 (	06	17516
	Physici		1. Decedent's Name (First, Middle, Last) $Viol$	et Loui	lse 0	Sarner	-				2. Date of Death Month MAY 31	Dav	06	3. Time of Death 9:27 A <sup>M</sup>
	/Medic Examin	_	4a. Facility Name (If not institution, give s.		)	·-·-·	4b. Cit		Location o	f Death		T	nty of Death	1 2.21 11
17 TO		ē .	Harbor Hospit  5. Social Security Number 6. Sex		ne (In vrs	last birthday)	If Und		imor		B. Date of Birth		N/A	A place (State or Foreign
28	Funeral Director			M 2□¥F	87		Month		Hours	Min.	(Month, Day,	<sub>Үөаг)</sub> 1919	Cou	inois
	pur		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	cation				,			10d. Inside City Limits
	Maryla a-f eho	tor	Maryland N/A			y, 10111 of 20	04(0)		Balt	imore				1 X Yes 2 □ No
	or 284	Director	10e. Street and Number				10f. Z	ip Code				g. Citizen o	of What Cou	ntry?
	ath w	ra l	1820 Spence Stree		. =				1230				USA	
36	be filed within 72 hours after death with the Maryland half lygiene.  ad other than "natural", or items 23a or 28a-f ehow event, the Madical Examiner must be notilied at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ※ Widowed 4 □ Divorced	<ol> <li>Was Decedent Armed Forces</li> <li>1 ☐ Yes 2 ☑</li> <li>If Yes, Give Year or Dates:</li> </ol>	7 No			edent of Hi ecify Cuba 2 🔯 No	ispanic Orig n, Mexican Specify:	gin? (Spec I, Puerto R	ify Yes or No- ican, etc.)		ace - Americack, White,	
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S	i Hygid Other	BeCc	17. Father's Name (First, Middle, Last)	, , , , , , , , , , , , , , , , , , , ,		<u> </u>	110111	andr.C.		r's Name (	First, Middle, M	laiden Sum		TOTAL
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altimore,	Page nent o ant: If ury or		1 ☐ Burial 2 ⚠ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specity)	emoval from State	9	emetery, crei	emato	ry,	Inc.			Ba1	timore	e. MD
Balt	permit. Pages Depertment of h Important: If its eny injury or of		21. Signature of Funeral Service Deense	M rchik		22	2. Name 299 ]	rede	ss of Facility	y Cre Road	mation Baltimo	Socie	ty of	MD. Inc.
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7	be sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a conseq	uence of):	` .	• • • • • • • • • • • • • • • • • • • •						
Ã	execute n and al-tran	Examiner	that initiated events resulting in death) Last	Due to (or a	Conseq	tense of):	CON	<b>,</b>						
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9	entifica ding pt	/Med	IF FEMALE:	3c. If yes, outcom	o of orogen	2001							\\	
.O. Box	that the death certific ed by the ettending p detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birth 4 Pregnant	2 Feta	Ideath 3	⊒Ectopic ⊒Other (	pregnancy specify)					Date of delive Month	ery Day Year
<u>α</u>	res that the signed by th be detache	by Pr	Part II. Other significant conditions con				ndertying	cause give	en in Part I.		23e. Did toba	acco use co	ontribute to t	he cause of death?
ord	w require been si should b	ted	KOIMONON	7 6	dev	NA					1 ☐ Ye	s 2 No	3 🗌 Prot	pably 4 Mulnknown
Vital Records,	e la	Completed							·		24a. Was an autopsy perform	/	o. Were auto prior to co death?	opsy findings available empletion of cause of
a		e Co	25. Was case referred to medical					-	00.01	(5. "	1 ☐ Yes 2	Ø <sub>No</sub>	1 Yes	2 No
Ž	Physician: this certific ral director,	0 0	examiner?	ospital:	tient 2X	P/Outpatier	nt 3□ [	Oth	20		(Check only one e 5 ☐ Resider		ther (Speci	fv)
n of	ng Ph íter th ineral	on: T	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of In (Month, D	jury	28b. Time o		28c. Injury Worl			3d. Describe how			7/
Division	Attending r death. ector: Atterby the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Ir	nium - At h	ome farm et	M reat facts		Yes 2 □ 1		of Location (Str	eet and Nur	wher or Rus	al Route Number.
Ω	itel or Attend is after death rel Director: ,	Certification:	4 Homicide determined	building, e	etc. (Specif	y)		ny, omos			City or Town,			ar riodie ridinoer,
	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one)  1. Ocertifying Physical Examination (Check only one)	ician: To the bes er: On the basis and manner s	of examina	wledge, deat tion and/or in	h occurre vestigation	d at the tin on, in my o	ne, date an pinion, dea	d place, ar th occurred	nd due to the ca d at the time, da	use(s) and r te and place	manner as s e, and due t	stated. o the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier				2	9c. Licens					ned (Month.	•
	1		J. New		WV			Di	230	462		6	1106	·
	H		30. Name and address of person who co		death (Item	n 23a) (Туре, <b>СЦС (</b>	Print)	JU )~	ad 8	2nad	6600	Rive	nìo -	MD 21061
£8	Sta		31. Date filed (Month, Day, Year)	700	trar's Signa	iture	Marie J	,,,,,,	(	~ vc		1001	ne,	1112 21001

State Claryland / Department of Health and Mental ygiene

		1- For State Registrar		Certifi	icate of	Death		R	eg. No.	UU	0 1/51
Physicia		Decedent's Name (First, Middle,	,Last)					Date of Dea     Month			3. Time of Death
ledical Exami	ner	Jamaal	S.			Gwalt		May 18, 2	2006		0245 hrs
		4a. Facility Name (if not institution, University of Maryland	, give street and number)		4	b. City, Town, Baltimore	or Location of De	ath	4c. County of	of Death	
Funeral		5. Social Security Number 6	6. Sex 7. Ag	e (In yrs. last i	birthday)	If Under 1 Ye	ear If Under 24	Hrs. 8. Date of Bi	rth(MM/DD/YYYY	9. Birth	place (State or
Director		220-98-3190	<b>™</b> 2 F	22	<b>23</b> Yrs.	Months Da	ays Hours N		)8 <del>83</del>	Foreign, Cour	
'n		Usual Residence of Decedent		100 City To	un es l'enstie					· .	And traids Ob. Louis
ow any		10a. State 10b. County NA		10c. City, To	un or Location ltimo						10d. Inside City Limits 1 X Yes 2 No
Aaryland 28a-f show 1 at once.	ctor	10e. Street and Number		Da.	1011110	10f. Zip Code		11	0g. Citizen of Wh		
e, MD 21215-0036  I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 'item 27 is marked other than "natural", or items 23a or 28a-f shorr traumatic event, the Medical Examiner must be notified at once.	Funeral Director	3105 Bentlou	Tamos Dia	<b>~</b>		·	21207		U.S		· y ·
with the second	ral	11. Marital Status	12. Was Decedent	Ever in U.S.		Decedent of I	lispanic Origin? (	Specify Yes or No	)- 14. Race	- America	an Indian, Black,
death or iten	nue	1 X Never Married 2 Mar	1 Yes 2	No			an, Mexican, Pue	rto Rican, etc.)	White		Black
after	by F		rced If Yes, Give Year or Dates:			Yes 2 X N			Specify:		
hours af 'natural Examin		15. Decedent's Education (Speci Elementary/Secondary (0-12)	fy only highest grade con College (1-4 or				eation (Give kind of fe. DO NOT use r		16b. Kind of Bu	siness/Ind	dustry
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215-0036 be filed within 72 tral Hygiene. ked other than '	Con	17. Father's Name (First, Middle, L	_ast)	L			18 Mother's Na	me (First, Middle,		-	
218 be fill sutal Fi	Be	Victor Gwaltn	ey					a Jacks			
21 should be nd Mer is mar	٢	19a. Informant's Name/Relationshi		I				or Rural Route Nur			21207
Baltimore, MD 21215-00 permit. Pages I and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the Me	. 3	Victor Gwaltn 20a. Method of Disposition	ey-Father			Bentlo		s Place	20c. Location -		
Baltimore, Department of Hee Important: If ite		1 X Burial 2 Cremation	3 Removal from Sta	ete cren	natory or other	er place)			1	,	
Itim it. Pay irtmen irtmen ortant		4 Donation 5 Other Spe 21 Signature of Funeral Service-L		KING				/25/06	Randa	IIS	town, Md
Balti permit Departm Imports injury o		Gerome F	J. Thomp	son	Mar 430	ch F/1	ss of Facility H West ash Ave	, Balti	imore,	Md	21215
Physician		23a. Pet I. Enter the disease, or c fall re. List only one cause o	omplications that caused		not enter the	e mode of dyin	g, such as cardia	c or respiratory arr	est, shock, or hea	art	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease	a. Shot gun wound		nultiple gu	nshot wour	nds (3)				Death
1		or condition resulting in death)	Due to (or as a conse	equence of):							
\	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	equence of):							
	ami	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	equence of):							<del></del>
cuted	al Exar		d								
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	ledical	UNPENDED	X AMENDED #7,	8,18,per	<b>IH,</b> C862	,12/29/0	6, <b>W</b> S				
8760, ifficate being physicase the bur	3	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcor			al death 3	Ectonic pred	mancy	23d. Date of Month	-	y Year
Box 687 c death certific the attending p	siciar	past 12 months?	4 Pregnant at	time of death		er (Specify)		inanoy	Worth	Da	ly real
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Division of Vital Records, tal or Attending Physician: The law requir is after death.  al Director: After this certificate has been selen by the funeral director, page 2 should the funeral director, page 2 should	Completed	·						autor	osy p		mpletion of cause of
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2	Į J	30. Name and address of person version of the colore King MD.		,		n Street, B	altimore, MD	21201			
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			1 - For State Registrar	State of	Maryla		artment of tificate of		Mental Hyg	giene2	06	17518
	Physici	an	1. Decedent's Name (First, Middle, La	•					2. Date of Dea Month		Year	3. Time of Death
	/Medic		Charles Leonard						May	31 2	006	7:30 p M
	Examin	er	4a. Facility Name (If not institution, giv Keswick House	e street and numi	ber)		Baltin			4c. County	of Death n/a	
	Funeral		5. Social Security Number 6. S	ex 7 MM 2□F		. last birthday)	If Under 1 Year Months Day		1. (Month, Day	, Year)	Cou	
	Director		218-26-5911 Usual Residence of Decedent		7	4			Apr 27	, 1932	Mary	rland
	nytan how		10a. State 10b. County		10c. C	ity, Town or Lo						10d. Inside City Limits
	Ba-f s	Director	Maryland n/a			Baltimo	ore					1 A Yes 2 No
	with th	Dire	10e. Street and Number				10f. Zip Code		1	log. Citizen of V		•
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0	s 1 and 2 should be filed within 72 hours efter death with the Maryland f Health and Mental Hygiens. I the first 71 is marked other than "natural", or Items 23a or 28a-f show other treumatic event, the Medical Evant or times for it cliffed at	by Fun	1 Never Married 2 Married	Armed Ford 1 Tes 2 If Yes, Give	es? Ş∤No	P	Yes, specify Cu		Specify Yes or No- rto Rican, etc.)		k, White,	can Indian, etc. nite
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	mit. F Dartme Poorter Injur		21. Signature of Funeral Service Licer	-			Cremator Name and Add		/03/2006 ubbard Fu			
Ŏ	Depariming Department of the sany in s		Will (	lind					ue, Balti			
	- 7		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cau	used the dea th fine.	th. Do not ente	or the mode of dy	ing, such as cardia	ic or respiratory arm	est,		Approximate Interval Between
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,	/Medical Examiner		resulting in death)	Due to (or	as a conse	quence of):						
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	te death certificate be executed the attending physician and hed for use as the burial-transit	edicai	(	d								
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2	r Atte er de: recto	Certification:	3 Suicide 6 Could not be determined	289. Place of	Injury - At h	ome, farm, stre	et, factory, office		281. Location (Str. City or Town,	eet and Numbe	r or Rura	Route Number,
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	To the Hospital of Attending Physician: The law requires that the death certif within 24 hours after death. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the be niner: On the basi and manne	s of examina	owledge, death ation and/or inve	occurred at the t estigation, in my	ime, date and place opinion, death occu	e, and due to the ca urred at the time, da	use(s) and mar te and place, a	ner as stand due to	ated. the cause(s)
	Withi To th	Σ	29b. Signature and title of certifier	10			29c. Licen	se number	29	d. Date signed	(Month, L	Day, Year)
	*			el h	0		DOE	61199		June, 1	. 3	-006
	10		30. Name and address of person who of Jason Black	6 56 5	of death (fter	n 23a) (Type, P L Char	rint) Les st,	Svite.	209, To	guson	m	Day, Year) 2006 0 2(204
	Stat Registra	_	31. Date filed (Month, Day, Year) JUN 0 5 20	06 32 Aeg	istrar's Signa	Sture Ap	role					

06-03772 Garv L. Holton Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day June 2, 2006 1738 hrs Holton **Medical Examiner** Gary 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number **Baltimore County** Middle River 9801 Tailspin Lane Apartment F 8. Date of Birth(MM/DD/YYYY) 9 Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 6. Sex 5 Social Security Number **Funeral** Months Days Hours Director April 7,1948 Country) Penna. 219 500091 1 XM 2 58 Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location Yes 2 X No Maryland Middle River Baltimore death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Apt "F" 21220 9801 Tailspin Lane USA 23a noti 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Black Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? items ust be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married Yes 0 Yes, Give Year 1967-73 Specify White 1 Yes 2X No specify: 4 X Divorced Widowed other than "natural" ð 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) or other traumatic event, the Medical more, MD 21215-0036
Pages 1 and 2 should be filed within 7
ient of Health and Mental Hygiene. State of Maryland Police Officer 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) If item 27 is marked Grace Edna Hagens Be Paul Holton Ernest 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1732 Manor Road Dundalk Maryland 21222 Diane Sufczynski sister 20b. Place of Disposition (Name of cemetery. 20c. Location - City or Town, State Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Holly Hill Mem Gardens 6/6/2006 Baltimore County Md Important: Other Specif Donation 22. Name and Address of Facility Fune al Service Licensee 1. Signature Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 mpfications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval art I Enter the disease, or c Physician Between Onset and failure List only one cause /Medical Death Contact Gunshot Wound of Chest mediate Cause (Final disease Examiner condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) If any, leading to immediate Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last ing physician and as the burial - tran Physician/Medical UNPENDED AMENDED Box 68760 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify, Yes 2 No 9 Unknown 9 Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. by 1 Yes 2 No 3 Probably 4 Unknown Completed Records, 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 26 Place of Death (Check only one) 25 Was case referred to medica Division of Vital æ Other<sub>4</sub> Nursing Home 5 Residence 6 ✔ Other Scene DOA Inpatient 2 ER/Outpatient 3 this ✓ Yes 28a Date of Injury (Month, Day, Year) FOUND: 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? To the Hospital or Attending within 24 hours after death Subject shot self Certification: FOUND: Natura Yes 2 V No 5 Pending Jun 2, 2006 1733 hrs Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be 3 V Suicide 9801 Tailspin Lane Apartment F, Middle River, M determined (Specify) Multi-Family Apt. To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d Date signed (Month, Day, Year) Signature and title of certifie June 3, 2006 O.C.M.E address of person who completed cause of death (Item 23a) 1041 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. Assistant Medical Examiner 31. Date filed (Month, Pay State

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Registra

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2006

			1 - For State Registrar	State of Mai	ryland /		rtment of H			giene () ()	6	17520
	Physici /Medic		1. Decedent's Name (First, Middle, Last, Lillie			На	11		2. Date of Dea Moeth	_	)06	3. Time of Death 9:30a м
	Examin	ner	4a. Facility Name (If not institution, give Future Care N. F		ođ		4b. City, Town, or Ball	Location of Deat timore	h	4c. County o	f Death NA	
ig.	Funeral Director		5. Social Security Number 6. Sec 224-05-8091	114 0532	(In yrs. last b 89	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 09-27	-1916	9. Birthpla Counti	va.
	how the training the training	_	Usuel Residence of Decedent  10a. State 10b. County  M d . N A		10c. City, To	wn or Lo					10	d. Inside City Limits
	h the Ma or 28a-1	Funeral Director	10e. Street and Number		Da	LL_L	10f. Zip Code		1	10g. Citizen of WI	nat Count	1 M Yes 2 □ No
	e 23s c	eral D	501 Dolphin Stre			1 10 1	1	217			SA	
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Important: If Item 27 is marked other then "naturel", or Iteme 23e or 28e-f ehow enty follury or other treumatic event, the Mudical Exaciliar matter notified at ance.	by	11. Marital Status  1 Never Married 2 Narried 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			Vas Decedent of His Yes, specify Cubar	spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	14. Race Black Specify:	, White, e	
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n L	es 1 an of Heal fitem 2 r other		20a. Method of Disposition		20b. Place	of Dispo	pen Way, A sition (Name of natory or other place			28803 20c. Location - C	ity or Tow	vn, State
altillo	it. Page ntment rtant: If njury o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donetion 5 ☐ Other (Specify)			g M	em. Pk.	6-2-				n, Md.
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VII	Physician: this certificatal director,	To Be	25. Was case referred to medical examiner?	ospital:	2 🗆 ER/O	utpatien	Otha		ith <i>(Check only</i> on ome 5 ☐ Reside		(Snecity)	
JINISIOII O	<b>□</b> = □	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day )	(ear)	Time of Injury			28d. Describe ho	ow injury occurred	1	
	Itel or At		4 Homicide determined	28e. Place of Injury building, etc.	(Specify)				City or Towr			
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	Medical	one)	sicien: To the best of ner: On the basis of e and manner state	xamınation a	e, death nd/or inv	occurred at the time estigation, in my opi	e, date and place inion, death occu	, and due to the carred at the time, d	ause(s) and mannate and place, an	ner as star d due to t	ted. he cause(s)
,	To Too	2	29b. Signature and title of certifier	8	MO	)	29c. License	number 74cS	2	9d. Date signed (	Month, Di	ay, Year)
	1,		30. Name and address of person who co	mpleted cause of dea	th (Item 23a)	(Type, I	Printle S	t. 3	altimo	e MI	)21.	20/
	Sta Registr		31. Date filed (Month, Day, Year)  JUN 0 5 20	32. Repistrar	s Signature	A	ale					

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		For		ryland / De	Indelible Ink. epartment of F Dertificate of	lealth and M	lental Hygi	iene 200	
		Registrar  1. Decedent's Name (First, Middle, Last	")		orimodio or	<i>D</i> 04	2. Date of Deat	g. No.	3. Time of Death
Physicia		THOMAS J. HALLE	Y. JR.				JUNE	1, 2006	11:35 A.
/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c. County of E	
_Admin	•	GILCHRIST CENTER			TOWSO	NC		BALTIN	MORE.
Funeral		<ol><li>Social Security Number 6. Se</li></ol>		(In yrs. last birth			8. Date of Birth (Month, Day,	9	Birthplace (State or Foreign Country)
Director		217-26-9968	]M 2□F	74 Yr	s.		4/3/19		MARYLAND
and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	or Location				10d. Inside City Limits
Aaryl f eho	5	MD BALTIMO	NDE	TOLICO	N.T.				1 □Yes 2X No
the h	Funeral Director	10e. Street and Number	re .	TOWSO	10f. Zip Code		10	og. Citizen of Wha	t Country?
3a or			D		210	96		TICA	
ma 2:	era	1501 DELLSWAY ROA	12. Was Decedent E	ver in U.S.	13. Was Decedent of F	lispanic Origin? (Spe	ecity Yes or No-		American Indian,
after or Ita	Fū	1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 DYYes 2 □ N	0		an, Mexican, Puerto	Hican, etc.)	100000000000000000000000000000000000000	White, etc.
raff, c	l by	3 ☐ Widowed 4 ☐ Divorced	If ♥ès, Give Year or Dates: p	COREAN	1 ☐ Yes 2 ☐ No	Specify:		Specify:	WHITE
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hen.	mpi	Efementary/Secondary (0-12)	College (1-4or 5-	+)	ife. DO NOT use retired	d)			
iled v lygie ther t		17. Father's Name (First, Middle, Last)	3 YEARS		MANAGER	18. Mother's Name	/First Middle A	SOCIAL S	ECURITY
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d Me d Me mark matic	ပ	THOMAS J. HALLEY  19a. Informant's Name/Relationship (T		19h M	Mailing Address (Street		IA MAGU		te. Zin Code)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itama 23a or 28a-f ehow any Injury or other traumatic avant, the Medical Examinar must be notified at once.			,, - ,	1220					8/2
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sician: The law certificate hes t irector, page 2 s	ĕ						perform	ed? deat	
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ttand death tor: , the f	cat	2 Accident investigation 3 Suicide 6 Could not be	One Place of laiv	n. At home form		Yes 2 No	39f Location /Str	and Alumbas a	r Rural Route Number.
after of Dirac	ertification;	4 ☐ Homicide determined	building, etc	. (Specify)	n, street, factory, office		City or Town		r nurai noble ivumber,
spital ours ours filled	O	29a. Certifier 1 Certifying Phy	/sician: To the best o	f my knowledge,	death occurred at the tir	me, date and place,	and due to the ca	use(s) and manne	r as stated.
To the Hospital or Attending Physicien: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate hes been signed by the ettending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical			examination and/	or investigation, in my o				
To th withir To th	M	29b. Signature and title of certifier			29c. Licens		1	d. Date signed (M	
11/		* A Come	nun			8303		JUNE 1	
02		30. Name and address of person who o	completed cause of de	eath (Item 23a) (T	ype, Print)	1 54 6		(0-0 0	
`\		AMON J. CHA	LLES on	5 6601	Sparke	2)1 11	in son	1-0 2	204
Sta		31. Date filed (Month, Day, Year)  JUN 0 5 2	ann 32. Registra	r's Signature	Snack !				
Registr	ar	3011 0 0 2	000	100 10	Party				

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Jacqueline Howard Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle,Last) hysician/ Examiner Month Day May 20, 2006 1935 hrs Howard Jacqueline 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1814 Maryland Avenue, Room 119 Baltimore 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number Country) MD Days Months Hours Min 62 12 08 43 216-84-4035 1 M 2 F Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 X Yes 2 No Baltimore NA MD Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number U.S.A. 21217 723 Appleton Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S Armed Forces? White, etc. 1 X Never Married 2 Married 2X No Yes Black Yes 2X No specify. 3 Widowed Divorced f Yes, Give Year Specify à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Unemployed na 9th grade Unemployed the Mee 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Unknown Marilyn Howard Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Poll+imore, Md 21215 19a Informant's Name/Relationship (Type, Print ) 3037 Woodland Ave, Baltimore, Md Caroline Howard-Sister 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Baltimore, Md 5/31/06 Zion Mt. Other Specify: 22 Name and Address of Facility
March F/H West
4300 Wabash Ave, ature of Funeral Service Licensee 21215 Baltimore, Md 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and failure. List only one cause on each line Death Cardiac arrythmia due to probable hypertensive cardiovascular diseas Immediate Cause (Final disease or condition resulting in death) Due to (cr as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ian/Medical item#23a,27,perME,G856,6/23/06 TT X UNPENDED AMENDED IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death 2 [ past 12 months? Pregnant at time of death 5 Other (Specify) Physic 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 🗸 Yes ✓ Yes 2 2 No 25. Was case referred to medical 26.Place of Death (Check only one)  $\mathbf{B}^{\mathrm{e}}$ DOA Nursing Home 5 Residence 6 Other: Scene Inpatient 2 ER/Outpatient 3 1 V Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number Signature and title of certifie May 21, 2006 O.C.M.E Je. 30 Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 gistrar's Signature 31. Date filed (Month, Day, Year) JUN 0

ORIGINAL

### Please Type or Print in Black Indelible Ink

ian Gary Jacque	State of Maryland / Department  1- For State  Certificate	of Health and Mental		. 2006 1752
Physician/	Registrar		2. Date of Death	3 Time of Death
edical Examine	Brian G. Jacque		June 1, 2006	
	Facility Name (if not institution, give street and number)     Good Samaritan Hospital	4b. City, Town, or Location of De Towson Baltimore		4c. County of Death
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday			MM/DD/YYYY) 9 Birthplace (State or
Director	218-84-1743   1×M 2 F 45	Yrs. Months Days Hours	Min. 11/03/1	960 Foreign Country) Maryland
	Usual Residence of Decedent			
w any	10a. State 10b. County 10c. City, Town or Le			10d Inside City Limits 1 Yes 2 X No
yland P-f sho	10e. Street and Number	10f. Zip Code	100	Citizen of What Country?
th the Maryland 23a or 28a-f show a notified at once.		21286	109	U.S.A.
r death with or items 23 nust be no	11. Marital Status 1 Never Married 2 X Married Armed Forces?	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue		14. Race - American Indian, Black, White, etc
", or it		Yes 2 X No specify:		Specify: White
nurs aft	l or Dates:	edent's Usual Occupation (Give kind		6b. Kind of Business/Industry
136 hin 72 hours e than "naturedical Exam	Elementary/Secondary (0-12)  College (1-4 or 5+)  Prir	ng most of working life. DO NOT use ncipal Chief 2		State of Maryland
215-0036 be filed within 72 intal Hygiene riked other than ent, the Medical Re Comple	The same of the sa	18.Mother's Na	ame (First, Middle, Maid	den Surname)  Ryncewicz
2121: buld be fill I Mental II: marked ic event,	19a. Informant's Name/Relationship (Type, Print ) 19b. Ma	ailing Address (Street and Number	or Rural Route Number	r, City or Town, State, Zip Code)
and 2 shou cealth and 1 is rem 27 is retraumatic	`	563 Yakona Rd., 1	*	21286 0c. Location - City or Town, State
E E E	1 X Burial 2 Cremation 3 Removal from State Holy Ros			Dundalk, MD
Baltimo permit Page Department o Important: injury or ott	21. Signature of Funeral Service Licensee William G. Dau	22. Name and Address of Facility F	Ruck Towsor	Funeral Home, Inc. 21204
Physician	23a Part I. Enter the disease, or complications that caused the death. Do not en failure. List only one cause on each line.			
/Medical Examiner	Immediate Cause (Final disease a. Hanging		<u></u>	Death
ac con	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.			
iner	if any, leading to immediate Due to (or as a consequence of):			
ed nsit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
be executed sician and unial - trans	UNPENDED X AMENDED item#4b,perME,	g856,6/5/06 TT		
68760, certificate buding physicse as the busing physicse as the busing	IF FEMALE: 23b. Was decedent pregnant in the			23d Date of delivery
cox 68760 eath certificate I eath certificate I eath certificate I for use as the by	past 12 months?  1 Live birth 2 Pregnant at time of death 5	Fetal death 3 Ectopic pre Other (Specify)	gnancy	Month Day Year
the death or by the attentched for us	1 Yes 2 No 9 Unknown 9 Unknown	Onler (opeany)		
P.O. es that the igned by to be detached.		he underlying cause given in Part I.		cco use contribute to the cause of death?  2  No 3 Probably 4 Unknown
aw requires that as been signed?			24a. Was an	24b. Were autopsy findings available
cords, law requir has been s			autopsy performe	prior to completion of cause of
of Vital Records, ng Physician: The law require ther this certificate has been si neral director, page 2 should b	l	20 21 2 2 2 2 2	1 ✓ Yes 2	
Vital   ysician:	examiner? Hospital: 1 Innation 3 of ER/Outpo	26.Place of Death (Che		sidence 6 Other
of Vir ing Physic After this funeral dir	. 27. Manner of Death 28a. Date of Injury 28b. Time		28d. Describe how	/ injury occurred
on tendin sath or: A the fur	1 Natural 5 Pending FOUND FOUND Jun 1, 2006 8829 hrs		Subject hange	d self
Division of spiral or Attending tours after death neral Director: Affilled in by the fur	2 Accident Investigation 3 Suicide 6 Could not be determined Could not be determined (Specify) Residence		or Town, State	et and Number or Rural Route Number, City e) Road, Towson, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours affect death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bunical Certification: To Be Completed by Physicial Medical Certification:	29a Certifier 1 Certifying Physician: To the best of my knowledge, death of		and due to the cause(s	and manner as started
To the Hos within 24 h To the Fun	one) 2 Medical Examiner: On the basis of examination and/or investigation and the basis of examination and/or investigation and the basis of examination and the	29c. License number		
2	29b Signature and title of certifier	O.C.M.E.		9d Date signed (Month, Day, Year)  June 2, 2006
10	30 Name and address of person who completed cause of death (Item 23a)			
$\varphi$		nn Street, Baltimore, MD 21	201	<u>.                                    </u>
Stat Registra	11111 0 = 0000	Soul!		
DHMH 17 Rev 1/200	ORIGI	NAL		

Please Type or Print in Black Indelible Ink

ames Johnson	State of Maryland / Department of Health and Mental Hygierie  I-For State  Certificate of Death  Reg. No. 2 () () ()	1752
Physician/	1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day  Year  0655	
Medical Examiner	James Anthony Johnson May 27, 2006  4a Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	11113
	Johns Hopkins Hospital Baltimore City	
Funeral Director		tate or
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside	de City Limits
<b>*</b>	MD Barermore	es 2 X No
h the Maryland 3a or 28a-f sh notified at one	10e. Street and Number 908 Southwick Drive 10f. Zip Code 21286 10g. Citizen of What Country? U.S.A.	
Baltimore, MD 21215-0036  permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "matural", or items 23a or 28a-f sho injury or other tranmatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status  1 Never Married 2 X Married 3 Widowed 4 Divorced of A Divorced of	
hours aftunatural"  Examine  ed by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry	
5-0036 ed within 72 hour tygiene. other than "natu the Medical Exan	Elementary/Secondary (0-12) College (1-4 or 5+)  12th grade na Electrical Maintenance City of Bal	timore
21215-0036 Juld be filed within 7. Mental Hygiene. marked other than ic event, the Medical TO Be Comple	17. Father's Name (First, Middle, Last)  18.Mother's Name (First, Middle, Maiden Surname)	
rould be fi rould be fi d Mental I is marked tic event,	James P. Johnson  Reatna Owens  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code	a).
MD 2 nd 2 shou alth and 3 m 27 is n anmatic	Griscelda Massie-Sister 908 Southwick Drive, Towson, Md 2128	
ore, MCss land 2 soft Health an Ifficen 27	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  Date  20c. Location - City or Town, Sta	te
Baltimore, permit Pages I at Department of Hee Important: If ite	Arbutus Memorial 6/2/06 Arbutus, Md	
Balt permit Depart Impor	22. Name and Address of Facility  March F/H West  4300 Wabash Ave, Baltimore, Md 21.	215
Physician	20a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximately Approximatel	mate Interval en Onset and
/Medical Examiner		Death
	Sequentially list conditions,  b	
iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause	
red Insit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
e be executed e be executed burial - transi	Xunpended   Amended item#23a,27,28a-f,perME,g856,6/8/06 TT	
'60, rate be o	IF FEMALE: 23c If yes, outcome of pregnancy 23d Date of delivery	
certific	23b Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day  4 Pregnant at time of death 5 Other (Specify)	Year
b. Box 687 the death certific by the attending p thed for use as the	1 Yes 2 No 9 Unknown 9 Unknown	
P.O. sthat the greed by the detache	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause  1 Yes 2 V No 3 Probably 4	_
Division of Vital Records, P.O. tat or Attending Physician: The law requires that the rs after death  "at Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach entification: To Be Completed by P	24a Was an 24b. Were autopsy find	
Records, The law requires freate has been sig, page 2 should be Completed	autopsy prior to completion  performed? death?  1 Yes 2 ✓ No 1 Yes	
al Re un: Th ruificat tor, pag	25. Was case referred to medical 26.Place of Death (Check only one)	2 No
F Vita Physicia r this ce al direc To Ba	examiner? 1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nursing Home 5 Residence 6 Other:	
n of inding P h	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  Find 5/27/2006 Find 6:30 am 1 Yes 2 X No unk	
ivisior  or Attend after death Director: d in by the	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street,and Number or Rural Route	Number, City
Division o spital or Attending hours after death neral Director: After filled in by the func Certification:	4 Homicide determined (Specify) Found at a recovery house Baltimore, MD	e ave.
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Medical Certification: To Be Completed by Physician/Medical Ex	29a Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	)
F % F %	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Y	'ear)
	O.C.M.E. May 28, 2006	
0	30 Name and adjress of jerso who completed cause of death (Item 23a)  Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201	7.0
State	31. Date filed (Month, Day, Year)  32. Registrar's Signature	
Registra		
DHMH 17 Rev 1/2001	ORIGINAL	

		•	For State Registrar	State of N		d / Depa		t of H	ealth a		ental Hy	_	06	17525	
	Physici		1. Decedent's Name (First, Middle,	Last) e11y							2. Date of De Month June	Day 1,2006	Yeer	3. Time of Death 1:55pm M	
	/Medic Examin		4a. Facility Neme (If not institution, 11721 Stonega		()			Town, or 1 umb	Location o	of Death			ty of Deeth rard		
	Funeral Director		116-28-7530	5. Sex 1 X M 2 ☐ F	Age (In yrs. 77	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bin (Month, Da Jan • 1	y, Year) 4,1929	9. Birthr Coul Utic	place (State or Foreign ntry) a, NY	
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  NY Nassa	u	10c. Cit	y, Town or Lo		City					1	10d. Inside City Limits	
	h with the 3a or 28a at bu noti	Funeral Director	10e. Street and Number 101 2ND Street	Apt A-5			10f. Zip	Code 530				10g. Citizen of USA	What Cou	ntry?	
036	be filed within 72 hours after death with the Maryland hal Hygiene id other than "natural", or Hems 23a or 28a-f show event, the Medical Examinar must be mullified at	by	11. Marital Status  1 Xever Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceder Armed Force 1 Yes 2 If Yes, Give	s? XNo		Was Deced If Yes, spec		spanic Ori n, Mexican Specity:	gin? (Spe n, Puerto F	cify Yes or No Rican, etc.)	BI	ace - Americ ack, White, ify: Whi	etc.	
Maryland 21215-0036	e filed within 72 ho al Hygiene. I other then "netur vent, the Wedforl	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12	Education grade completed) College (1-40 5+	r 5+)		dent's Usua kind of woi DO NOT us ofess	rk done d e retired	ation Juring mos	t of workir	ng	16b. Kind of Educ	Business/In	•	
yland	ed also	To Be C	17. Father's Name (First, Middle, L. Daniel V. Ke	11y					Wir	nifre	d Stanı				
, Mar	nd 2 sho aith and 27 is m r traum		Daniel Kelly /		205	35	Hidde	n Me	adows	s Dri	ve Berg	gen, NY	14416		
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.	ecity)	(8)	Place of Disponentery, crer Mary	's Ce	mete	ry	June 200	6		on, NY		
Ball	permit. Departr Imports any inji		21. Signature of Funeral Service L				1501	East	Fort	Ave B	Funeral Home Inc.  Baltimore MD 21230  or respiratory arrest. Approximate				
Physician pe executed / Medical Examiner   Physician and phrial-fransit		lical Examiner	23a. Part1. Enter the disease of or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Metas Due to (or :  b. Due to (ur :		Cance. quence of):								Interval Between Onset and Death	
.O. Box 68	The law requires that the death certificate I ate has been signed by the attending physicage 2 should be detached for use as the I	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcon 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	aldeath 3□	Ectopic pr Other (sp					1	ate of deliver	ery Day Year	
Δ.	quires that t in signed by uld be deta	by	Part II. Other significant condition	s contributing to death	but not res	sulting in the u	nderlying c	ause give	en in Part I			obacco use co ∕es 2 □ No		he cause of death? pably 4 Sunknown	
of Vital Records,		Completed											Were auto prior to co death? 1 🗌 Yes	ppsy findings available impletion of cause of 2 No	
f Vita	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 🗆 Inpa	atient 2	ER/Outpatier	nt 3 DC	)A Othe	ar-		(Check only only only one 5 ☐ Resid	ine) dence 6 🗹	4 ther <i>(Specit</i>	y) RESIDE XE	
Division o	utending Ph death. ctor: After th y the funeral	Certification:	27. Manner of Death  1 Natural 5 Pending investigi	ition	njury Day Year)	28b. Time o Injury	f 2	8c. Injury Work	vat ⟨? Yes 2□	No		now injury occu			
Divi	ire n		3 Suicide 6 Could n. 4 Homicide determin	200. Flace 01	Injury - At h etc. (Speci	ome, farm, str	reet, factory	, office		2	8f. Location (S City or Tox		nber or Rura	al Route Number,	
	To the Hospital of within 24 hours at To the Funeral D completely filled it	ledical	(Check only 2 Medical E	Physician: To the be xaminer: On the basis and manner	of examina	owledge, deat ation and/or in	vestigation	, in my of	oinion, dea	id place, a ith occurre	ed at the time,	date and place	, and due to	o the cause(s)	
	To To Corr	Σ	29b. Signature and title of certifier	ene MD			290	D16	number 619			29d. Date sign June		* * * * * * * * * * * * * * * * * * * *	
	10		30. Name and address of person v					Dr.	Balti	.more	MD 212	236			
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  JUN 0 5		strar's Sign	di A	sark	,							

			For Stata Ragistrar	State of		d / Depa		t of H	ealth a	and M	lental Hy	giene			7526
				(		Cei	lincale	e OI L	Jealii			Rag. No.			To a Deat
	Physici	an	<ol> <li>Decedent's Name (First, Middle Amount Amount</li></ol>	, Last)		Ka		00			2. Date of De. Month	Day	Year		. Time of Death
	/Medic		ANNA	<u> </u>	-	110	HLE				JUNE				5:45 AM
	Examin	ier	4a. Facility Name (If not institution	-	ber)				Location of			4c. (	County of Dea		
			1901 E. Pratt	Street			1		imore		-			]	N/A
	Funeral		5. Social Security Number	6. Sex 7 1 ☐ M 2 🖫 F	. Age (In yrs. 81		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da 2/16/19	h y, Year)	9. Bi	irthplace Country)	(State or Foreign
ш	Director		219–12– 5724	ILIM ZIZIF	01	Yrs.					2/16/19	925		1D	
	D .		Usual Residence of Decedent  10a. State 10b. County		100 Cit	y, Town or Lo	vation							100	Inside City Limits
	shov	_	MD N/A		100.01	y, rown or co		al+i	more	Ci+	,				1 Yes 2 No
	Be-1	cto							HOLE	CIC	<i>!</i>				
	d within 72 hours after death with the Maryland jiene. r then "naturel", or Items 23e or 28e-1 show the Medical Evaminar must be notified at	Director	1901 E. Pratt S	treet			10f. Zip	Code 2	1231			10g. Citiz	en of What C	Country?	?
	23e														
	ems	Funerai	11. Marital Status	12. Was Deced	lent Ever in U ces?	.S. 13.	Was Deced	lent of Hi	spanic Ori	igin? (Spen, Puerto	ecify Yes or No Rican, etc.)	. 1	<ol> <li>Race - Am Black, Wh</li> </ol>		
9	or It	F	1 Never Married 2 Marr	ied 1 □ Yes 2 If Yes, Give	No No		1 ☐ Yes 2		Specify:			1		7hite	
8	ours irel',	dby	3 Widowed 4 □ Divorced	Year or Dat	es:										
5-(	72 h natu	Completed	15. Deceden (Specify only highes	s's Education of grade completed)		16a. Dece (Give life.	dent's Usua kind of wor	Il Occupa rk done a	ation <i>furing m</i> os	t of work	ing	16b. Kin	d of Busines:	s/Indust	try
2	within 72 liene. then "nat	ldu	Elementary/Secondary (0-12)	College (1-		life.						C+	ate of	= MT	
2	e filed within al Hygiene. i other then vent, the We	Co	12		0		Acc	ount	s & P					עניו .	
nd	be filed Ital Hyg od othe event,	Be	17. Father's Name (First, Middle,	Last)							e (First, Middle.	Maiden S	Sumame)		
<u>la</u>	should be ind Mental marked o	2	Henry Heck						Mar	cie F	Rogers				
Maryland 21215-0036	and and sm	0 8	19a. Informant's Name/Relations Michael H. Bur		on						Al Route Numbe				de)
_	1 and 2 Health lem 27		Michael n. bul	ulliski / S					LL SI		, Balti				
ore.	of He		20a. Method of Disposition 1   Burial 2 □ Cremation	2 □Bamoual from S		Place of Dispo cemetery, crei	matory or or	ther place	e)		Date		ation - City o		
Ĕ	Page nent int: If		'4 □Donation 5 □Other (S		Cr	ownsvi.	lle V	eter	ans (C	<i>l</i> emet	ery 06/	6/20	06 Cro	wnsv	ville MD
Baltimore,	permit. Pages 1 a Department of He Importent: If Item any njury or othe		21. Signature of Funeral Service	Licensee		22	2. Name an	d Addres	s of Facili	ty	_	3			
Ö	B E E B	ļ.	77	) Actor	P. Do	da, Jr.	Charle 1501 i	es L E Fo	. Ste	vens	Funera e, Balt	I Ho	me, In	C.	n
	-		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca	used the deat	h. Do not ent	ter the mode	e of dying	g, such as	cardiac o	or respiratory a	rest,		Apı	proximate erval Between
. UE			Immediate Cause (Final											On	iset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. SEPS	or as a conseq	uence of):									WEEK
	Examiner			b. GANG					OOT	-				-	And been to
1		ē	Sequentially list conditions, if any, leading to immediate		r as a conseq			11	COL					13	MONIGS
H	nsit ad	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	AIZL	LEIME	2'5	DIS	EA	SE					7	MONTHS
4	al-tra	Examiner	that initiated events resulting in death) Last	C. Due to (c	r as a conseq	uence of):		) <u>C</u>							101123
,092	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	cai		d.											
687	physi physi s the t			d											
×	leath certificat attending phy I for use as the	¥.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregna	ancy						2	3d. Date of de	elivery	
Вох	atter for u	ciar	in the past 12 months?		th 2 Feta nt at time of d		□Ectopic pro □ Other (sp						Month	Day	y Year
o.	he di the ched	Physician/Med	1 □ Yes 2 █No 9 □ Unknown	9□ Unknow			, -,	//							
ď.	that the de ned by the a detached		Part II. Dthar significant condition	ons contributing to dea	ath but not res	ulting in the u	nderlying ca	ause give	en in Part I		23e. Did to	obacco us	se contribute	to the ca	ause of death?
Records,	sign sign d be	d by									10	/es 2 5	No 3□F	Probably	4 Unknown
Ö	w require been sij should b	Completed									04-146-		045 144		Code a service la
%ec	e law	npi									24a. Was		prior to death?	comple	findings available etion of cause of
F		Co									1 ☐ Yes			s 2 🗆	No
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medica examiner?					Other		of Death	n (Check only o	ne)			
of	Physi this c	P	1 ☐ Yes 2 🗷 No		patient 2				4 🗆 140	-	me 5 Resid			ecify)	
		on:	27. Manner of Death 1 ☑Natural 5 ☐ Pendir	28a. Date of (Month	n Injury 1, Day Year)	28b. Time o Injury		8c. Injury Work	(?		28d. Describe I	now injury	occurred		
Sio		cati	2 Accident investi	not be			М		Yes 2□	1.0					
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	rs at			<u> </u>											
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	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	led	one)	and mann	er stated.			1.				001 0-1-	-:		- V d
	To To	Σ	29b. Signature and title of certifie	1/					number				signed (Mon		
	10		tenta	Hono	60.		I	16	203	2	۷.	JUNG	02	2	2006
	n		30. Name and address of person	•	of death (Iter	п 23а) (Туре,	Print)		0						
			0 5 11 10 1 000	MD 5505	TOPKIN		IEW CI	RCLE	5 DA	HUTIMU	ORE, MI	21	224		
		atė	31. Date filed (Month, Day, Year)		gistrar's Signa	ature	0		•		-				
	Regist	rar	JUN 0 5	2006	Adding .	H A	melle								

		•	For State Registrar	State o	f Marylan		artment of H			giene 2 (	006	17527
			Decedent's Name (First, Middle, La	st)	·				2. Date of Dea	ith		3. Time of Death
	Physici		Harry Rea	Kaf	er				June 1	, 2006	Year	6:30 AM
-	/Medic Examin		4a. Facility Name (If not institution, giv	e street and nu	mber)		4b. City, Town, or	Location of Death		_	y of Death	
			Genesis Eldercare	Bright	wood Ce	enter	Lutherv	ille			Balt	imore
	Funeral		Social Security Number 6. 8		7. Age (In yrs.		tf Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	n v, Year)	9. Birthp	olece (State or Foreign ntry)
	Director			XM 2□F	85	Yrs.			Sept 2	2,1920		/lánd
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	10d. tnside City Limits
	Aaryli - ho	5										1 ☐ Yes 2 ☐ No
	28a-	ect	Maryland Baltimon  10e. Street and Number	re	I WN1	te Mar	SN 10f. Zip Code			10g. Citizen of	What Cour	
	a or	Funeral Director	5814 Pine Hill Dr	ri ve	-			162			US	
	ne 23	era	11. Marital Status	12. Was Dece	edent Ever in U	.S. 13. V	Was Decedent of Hi	ispanic Origin? (S	pecify Yes or No-	14. Ra	ice - Americ	
36	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. is marked other than "neturel; or iteme 23a or 28a-f ehow aumatic event, the Medical Enginer must be notified at	by Fur	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Amed Fo	2 🗌 No		f Yes, specify Cuba 1 □ Yes 2 🛣 No	n, Mexican, Puert Specify:	o Rican, etc.)	Spec	ack, White, ify: Wh	etc. ite
2-0036	eture	ed	15. Decedent's E	ducation		16a. Deced	dent's Usual Occupa	ation		16b. Kind of		
212	within 72 ane. than "net	Completed	(Specify only highest gr. Elementary/Secondary (0-12)	college (1	I-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of wor ()	king			
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g	be filed htat Hygie of other event, to	Be (	17. Father's Name (First, Middle, Last	)					ne (First, Middle,	_	_ `	
Maryland	ould b Ment Merke arke	၉	August Kafer					Magda		Marke		
Mar	12 sh h and 7 is m		19a. Informant's Name/Relationship (				g Address (Street a					
	1 and Healt em 2		Janet Davis (nied 20a. Method of Disposition	æ)	20b. F	Place of Dispo	Scotts Ha sition (Name of	<u> </u>	<i>r</i> e Parkvi Date	LLLE Ma 20c. Location	-	
٥	ages nt of t: if it		1 Burial 2 Cremation 3		State	semetery, crer	natory or other plac	· 1	E 2006 T			
Baltimore,	ortane ortane injury		21. Unature o Funeral S rvice Lice		() loan		Cemetery  Name and Addres		5,2006 I			
Ba	permit. Pages 1 and 2 should be Deparlment of Health and Menta Important: if item 27 is marked any injury or other traumatic ex		# 120	$\times$	X		07 Old Ea					
			23a P. t1. Enter the disease, or comshick, or heart failure. List only	plications that o	aused the deat						7 4 4 4 4	Approximate Interval Between
	Physician		Immediate Cause (Final	one cause-sine	end S	Svale	nena	e Du	eare		١.	Onset and Death
7	/Medical		dise se or condition resulting in death)	aDue to	(og as a conseq	uence of):						month
	Examiner		Sacrantially let conditions	b (	and	wm	yopau	57			r	nonas
	ס ב	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to								
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387	icate phys s the	dicai		_ d								
×	eath certific attending p	N.	IF FEMALE: 23b. Was decedent pregnant		come of pregna					23d. D	ate of delive	erv
.O. Box	the death certifi y the attending I iched for use as	Physician/Me	in the past 12 months?	4☐Pregr	oirth 2 ☐ Feta nant at time of d		Ectopic pregnancy Other (specify)				onth	Day Year
o.	res that the de signed by the a be detached f	hysi	9 Unknown	9□ Unkn	own							
ري ص	s that ned b	by P	Part II. Other significant conditions	contributing to d	eath but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use cor	ntribute to th	he cause of death?
Division of Vital Records,	The law requires that ste has been signed b sage 2 should be deta	ed tr							1□ Y	es 2 🗆 No	3 Prot	bably 4 Othknown
000	e lawre has be je 2 sho	Completed							24a. Was a		Were auto	psy findings available impletion of cause of
œ —		ĕ							perfor		death? 1 ☐ Yes	
<u>ita</u>	Physicien: r this certific ral director,	Be	25. Was case referred to medical examiner?						th (Check only or			
×	hysic this o	၉	1 ☐ Yes 2 ☐ No			ER/Outpatien		er: A Nursing H	ome 5□Resid	ence 6 □Ot	her (Specif	y)
Ĕ	ding Physicien:  After this certific funeral director,	<u>0</u>	27. Manner of Death 1 □Natural 5 □ Pending	1 .	of Injury th, Day Year)	28b. Time of tnjury	Work	ς?	28d. Describe h	ow injury occu	rred	
<u>s</u>	tend leat lor: the	cat	2 Accident investigation 3 Suicide 6 Could not be	e One Blace	of laiun. At h			Yes 2 □No	29f Location /C	troot and Mum	hor or Russ	al Route Number.
<u>&gt;</u>	i or Attene efter deatl Director: I in by the	Certification:	4 Homicide determined	buildi	ng, etc. (Specif	y)	eet, factory, office		City or Tow	n, State)	Dei UI Mula	i Aoute Number,
	spita nours neral fillec	a C	29a. Certifier	nysician: To the	best of my kno	wledge, death	occurred at the tim	ne, date and place	, and due to the c	ause(s) and n	anner as s	tated.
	To the Hospital or At within 24 hours efter of To the Funeral Direct completely filled in by	edicai	(Check only 2 Medical Example)	miner: On the b	asis of examina ner stated.	ition and/or in	vestigation, in my op	oinion, death occu	rred at the time, o	late and place	, and due to	) the cause(s)
	with To t	ž	29b. Signature and title of certifier				29c. License	e number	2	29d. Date sign	ed (Month,	Day, Year)
	14.			e MD			DOC	5315	0	TUNE	154	2006
1	011		30. Name and address of person who	completed caus	se of death (tten	n 23a) (Type,	Print)	ماء ً م	0	Su	le 11	0
	\ 		Shown ms	22 0	Sup t	eture	20 25	richo	10000	1 00	comi	21045
	Sta Registi		31. Date filed (Month, Day, Year)	2006	Estate a	# 1	hade!					2006 0 0 21045
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 30 4:35 PM KANE HELEN MAY 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2018 E. Baltimore Street Baltimore NA 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🗓 F Yrs. 217-22-8901 80 08-24-1925 Director Md. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show 1 Yes 2 □ No Director Md. Baltimore NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2018 E. Baltimore Street 21231 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □**X**es 2 □ No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: <u>Ş</u> Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) . Pages 1 and 2 should be filed wi ment of Heatth and Mental Hygien tant: If item 27 Is marked other th jury or other traumatic event, the 8th grade Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hutchins Ella Mae Joseph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21231 Charles W. Kane Husband 2018 E. Baltimore Street, Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: if any injury or once. Garrison Forest Vet. 6-6-06 Owings Mills, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. On not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician a PARKINSON'S DISEASE 14 YEARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner ed by the attending physician and detached for use as the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 21200 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown DECUBITUS, CHRONIC RENAL FAILURE Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? HYPERTENSION, STROKE, HYPUTHYROIDISM 2□ No 1 ☐ Yes 2 No 1 Tyes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be determined 3 🖺 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D6203Z 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAYVIEW CIRCLE BALTIMORE, MD 21224 (JENNIFER HAYASHI) HOPKINS 31. Date filed (Month, Day, Year) 32. Engistrar's Signature State JUN 0 Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

		•	For State Registrar		State of	Marylan	-	artment of F				giene	006	175	29
	Physici /Medic		1. Decedent's Name (First, Midd		+z					2	2. Date of Dea Month May	Day	Year 2006	3. Time of De 17:15	eath M
	Examin		4a. Facility Name (If not institution U.M.	-					3 a 1+1	imore			unty of Death		
	Funeral Director		5. Social Security Number  222-20-1243  Usual Residence of Decedent	6. Sex 1 ☐	м 2 <b>ј</b> ДF	Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8	Date of Birt (Month, Da) 11/29/	h Y. Year) 1934	Cou	place (State or Fi ntry) AWARE	oreign
	Maryland f show	or	10a. State 10b. County	SSEX		10c. Cit	y, Town or Lo							10d. Inside City L	
	th the P	irect	10e. Street and Number					10f. Zip Code		<del></del>		10g. Citizen	of What Cou	ntry?	
	ath wi	rai	280 REHOBOTH E						971				SA		
920	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heelih and Menial Hygiene.  If item 27 is marked other than "netural", or iteme 23s or 28s-f show or other fraumatic event, it is Medical Examinational Candified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Ma  3 ☐ Widowed 4 ☐ Divorce	ried	2. Was Deced Armed Force 1 Tes 2 If Yes, Give Year or Date	es? □XNo	1	Was Decedent of H t Yes, specify Cuba 1 ☐ Yes 2(X) No			rty Yes or No- ican, etc.)	i	Race - Ameri Black, White ecify: WH		
21215-0036	vithin 72 ho ne. hen "netur e Medical	Completed	15. Decede (Specify only higher Elementary/Secondary (0-12) 12TH GRADE			lor 5+)	(Give	tent's Usual Occup kind of work done DO NOT use retired	during mos 1)	t of working	7		of Business/Ir		
	ild be filed v lental Hygie ked other t Ic event, IL	To Be Co	17. Father's Name (First, Middle TAYLOR DUGGAN				<u> </u>	OMEMANER	18. Mothe	er's Name (	First, Middle,	Maiden Sun	mame)		
Maryland	d 2 should be th and Mental ?7 is marked o traumatic eve	-	19a. Informant's Name/Relation JOHN D. KLEITZ					ng Address (Street			Route Numbe		wn, State, Zi 958	Code)	
Baltimore,	permit. Pages 1 and 2 Depertment of Heelth s Important: If item 27 it eny injury or other tra ance.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Re		ate	Place of Disponentery, crem	sition (Name of natory or other place	ce)	Da 6/7/2	te	20c. Location	on - City or T		
Baltir	permit. P Depertme Importan eny Injur		4 Donation 5 Other (Specify) GRACELAWN  21. Signature of Funeral Service Licensee 22. Name and Address of 8521 LOCH R.								JOHNSO		ERAL HO		1.
760,	Physician // Medical // Medical // Medical // Examine prijeliusii	ical Examiner	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. b. c.	Due to (o	Sepsionseq	uence of): cysfif uence of):	rìs						Interval Between Onset and Dea	ath
P.O. Box 68	The law requires that the death certificate be ex sie has been signed by the ettending physicien page 2 should be detached for use as the burial	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23		th 2 Feta nt at time ot d	I death 3	Ectopic pregnancy	/			23d.	Date of delive	ery Day Yea	ar
	quires that in signed b uld be deta	by	Part II. Other significant condit	ons cont	ributing to dea	th but not res	ulting in the u	nderlying cause giv	en in Part I			obacco use d		he cause of deal	
I Records,	The law re ate has bee page 2 sho	Completed									24a. Was autop perfo 1 Yes	rmed?	4b. Were autoprior to condeath?	opsy findings ava impletion of caus	ailable se ot
Vital	Physician: r this certifica ral director, p	Be	25. Was case reterred to medic examiner?	-	ospital:			oth Oth	000		Check only o				
o	e fe	ation: To	E L Mooidoin	ng igation	28a. Date of (Month	patient 2 Injury , Day Year)	28b. Time of Injury	f 28c Injur	4 🗆 140	28	e 5 Resid			(y)	
Division	rs after de el Directo	27. Manner of Death   1   Natural   28a. Date of Injury   28b. Time of Injury   28b. Time of Injury   28c. Injury al Work?   1   Yes 2   No   28c. Describe how injury occurred   28d. Describe how injury occurre								al Route Number	r.				
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edicai	(Check only 2 Medics	I Examin	cian: To the been on the base and manner	is of examina	wledge, deat tion and/or in	vestigation, in my o	pinion, dea	nd place, ar ath occurred	d at the time,	date and pla	ce, and due t	o the cause(s)	
	To t To t	Σ	29b. Signature and title of certification.		redges	M.D.		29c. Licens	P 19	665		29d. Date sig May	gned (Month,	Day, Year) 2006	
(			30. Name and address of perso	who con		of death (Iten		Print) S. greene			imore				
	Sta Regist		31. Date tiled (Month, Day, Yea JUN 0	")	6 32. 9	gistrar's Signa	ature	porte							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien () For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 6.59mm MATTHEW LOUIS KOLB, JR. 2 nd 2006 Tune /Medical 4a. Facility Name (If not institution, give street and number)
Good Samaritan Hospital 4c. County of Death 4b. City, Town, or Location of Death Examiner Balt imore N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign
Country) 6. Sex **Funeral** Months Days Hours 1**X**M 2□ F 215-05-9037 1, MARYLAND Director 1917 Usual Residence of Decedent 10d. fnside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show : if item 27 is marked other then "naturel", or items 23a or 28a-f shov or other treumatic event, the Madical Examinar hard be recitived at 1 ☐ Yes 2 ☑ No Directo MD BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1522 ORLANDO ROAD 21234 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 2√☐ No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates: 1945-46 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MARTIN MARIETTA YRS. ENGINEER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be t and 2 should be fi dealth and Mental F ۵ MATTHEW LOUIS KOLB, SR. MARY KOMENDA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Importent: If Item 27 Is any injury or other tree 4050 WALTER AVENUE FALTIMORE, ND 21236
Date 20c. Location - City or Town, State LESLIE FAULKNER/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐xBurial 2 ☐ Cremation 3 ☐ Removal from State MORELAND MEM. PARK 6/5/06 HILLENDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee 22. Name and Address of Facility 21. Signature THE JOHNSON FUNERAL HOME P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each fine. Approximate Interval Between Onset and Death Immediate Cause (Final n difficile colitis Physician Clostridiu disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Urosepsi 1 ☐ Yes 2 ☐ No 3 Probably 4 Honknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 100 2 -NO Be 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 Dispatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**O မ 1 🗌 Yes 2 ER/Outpatient 3 DOA After this funeral dis 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation s after dec. 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) filled in by 4 🗌 Homicide Hospital or 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated To the the th 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MBChB

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) JUN 0 5 2006

Mukhenee

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)



06 02 2006

BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physi ian 4:40 PM GLORTA KLEIN JUNE 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Exam** her BALTIMORE HOSPITAL HARBOR If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M Director 82 **DECEMBER 21,1923** MY 104.16.3588 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits Hygiene. other than "naturel", or iteme 23a or 28a-f ehow rent, the Madical Examinar must be notified at 10a State 10b. County 1 ☐ Yes 2 ☐ No Directo **FERNDALE** MD ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 1 1st AVE S death by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, GiveXX Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours atler nen of Health and Mental Hygiene, ent: if item 27 ie marked other than "naturel, or ite ary or other traumatic event, the Madical Examina 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes XX No Specify: Specify. WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOME MAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 CHARLES OSTROWSKI HELENA BRYNIARSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KURT ERIC KLEIN SON 815 BROADVIEW BLVD FERNDALE, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or once. 4 Donation 5 Other (Specify) CEDAR HILL CEMETERY 6.6.2006 BROOKLYN, MD 22. Name and Address of Facility FINK FUNERAL HOME, P.A. 21. Signature of Juneral Service Licens GREGORY FUNK M01148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Part1. Enter the disease, or complishock, of heart failure. List only or Approximate Interval Between Onset and Death 23a. Part1 Immediate Cause (Final disease or condition resulting in death) ACIDOSIS 2 DAYS Physician DITIA. /Medical Due to (or as a consequence of): Examiner CHOLANGITES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physicien and s the burial-transit law requires that the death certificate be executed CHOLELITHIASIS Due to (or as a consequence of): Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed HYPER LIPIDEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 1 ☐ Yes 2 ♣No 2 No 1 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 

In financial formation of the second of the Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 3 DOA After the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 KNatural 5 Pending 1 Tes 2 No hours efter death uneral Director: A sly filled in by the fi investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours e To the Funeral I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar 29b. Signature and title of certifier Mydnitar

SOUTH

, M.D.

2006

imore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

HANOVER - STREET, BALTIMORE Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RACHANA PALNITKAR, HARBOR HOSPITAL.

RES 000

29d. Date signed (Month, Day, Year)

JUNE 1, 2006

MARYLAND 21225

			1 - For State Registrar	State of Ma		nd / Depa		of He	alth a				חל	06	175	32
			1. Decedent's Name (First, Middle, Las	)							2. Date of Dea			.,	3. Time of	Death
	Physici		Marjory	E. Kri	Z						June 1.	20 20		Year	9:45	РМ
	/Medic Examir		4a. Facility Name (If not institution, give				4b. City, To	wn, or Lo	ocation of		3440 1	_		of Death	7.72	
	Zxamii		930 Astern Way,				Α	nnan	olis				Anne	e Aru	nde1	
	Funeral		5. Social Security Number 6. Se	x 7. Age	e (In yrs.	last birthday)	If Under 1	Year 1	If Under 2		8. Date of Birt				lace (State o	r Foreign
н	Director		397-05-9347	⊐м 2С <b>Х</b> F	87	Yrs.	Months (	Days	Hours	Min.	8. Date of Bird Month, Day APR 4,	191	9		onsin	
	P .		Usual Residence of Decedent		1									,,,,,,	OHOTH	
	how	_	10a. State 10b. County		10c. Cit	ly, Town or Lo								1	Od. Inside Ci	
	6 Ma	cto	Maryland Anne Ar	undel		Anna	polis								1 🗌 Yes	2 <u>N</u> No
	or 28	Oire	10e. Street and Number				10f. Zip C					10g. Citi		What Coun	try?	
	72 hours after death with the Maryland 'naturel', or Iteme 23a or 28s-f ehow disal Examiliar must be notified at	Funeral Director	930 Astern Way, A	pt. 206				2140	)1				Ţ	JSA		
	e E	ne	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U	.S. 13. \	Was Deceder	nt of Hisp	anic Origi Mexican	in? (Spec	cify Yes or No- Rican, etc.)			e - Americ		
9	or it	F.	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 🛣 N If Yes, Give	No		□ Yes 2	7	Specify:				Specify			
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2	filed v Hygie other t		17. Father's Name (First, Middle, Last)	4		nea.	1 Esta			la Mana	(Fine 14)-1-1-					
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Ĕ	should nd Mer marke umartic	P	Sigvald Stavrum								y Taylo					
Maryland 21215-0036	0 a = 5		19a. Informant's Name/Relationship (T) Carey Kriz/Son	rpe, Print)							Route Numbe				Code)	
a)	fand fealth im 2				20h E				ove		apolis,					
Baltimore,	permit. Pages 1 and Department of Health Important: if item 27 eny injury or other ti		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ I	Removal from State	0	Place of Disposemetery, cren	natory or othe	er place)			ate	20c. Lo	cation -	City or To	wn, State	
<u>ٿ</u>	tmen tant: jury		4 □ Donation 5 □ Other (Specify)		Met	tro Cre								ore,		
3al	Deparit		21. Signature of Funeral Service Licens	ee ll		22	. Name and	Address	of Facility	Cre	mation	Soc:	iety	of l	D, In	c.
_	40 E 9 9		Edward A. Greg	orchik							Balti					
	Physicien and // Medical Example prize pri	cal Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last	Due to (or as a Due to for as a Due to for as a	nan a conseq a conseq a conseq	yence of): Veople uence of):	gen gen	DIE	rasi	<u> </u>					Interval Betw	
99	tificat ig phy as th				/			1	U							
P.O. Box	To the Hospital or Attanding Physician: The law requires that the death certifica thin 24 hours after death. To the Funers after death. To the Funers all Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 1 4 ☐ Pregnant at 9 ☐ Unknown	2 Feta	Ideath 3	Ectopic preg Other (speci					2	3d. Dat Mor	e of delive	,	ear
<u>ر</u> س	s that med t	Y P	Part II. Other significant conditions co	ntributing to death bu	ut not res	ulting in the un	derlying caus	se given i	in Part I.		23e. Did to	bacco u	se contr	ibute to the	cause of de	ath?
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æ	he la e ha age 2	E									autops	ned3/	d	leath?	sy findings a pletion of ca	use of
ā	ifficat or, p		25. Was case referred to medical						a Di	(D11-1	1 Yes		1	Yes	2 No	
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Division of Vital Records,	nding Phy th. : After this e funeral c		27. Many of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	у	28b. Time of Injury		Injury at Work?		28	e 5 Peside 3d. Describe ho					
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	in 24 hour in 24 hour he Funer pletely filt	Medical	29a. Certifier 1 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best oner: On the basis of and manner state	examina	wledge, death tion and/or inv	occurred at testigation, in	the time, my opini	date and on, death	place, ar occurred	nd due to the ca	ause(s) ate and	and mai place, a	nner as sta and due to	ited. the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier	2			29c. L	icense nu	umber		2	9d. Date	signed	(Month, E	ay, Year)	
•			) Cyllin	11			1	13	199	77		J111	ne 2	2, 200	06	
	10		30 Name and address of person who co	impleted cause of de	eath (Item	23a) (Type, F	Print)							,		
	10		HNDREW GORDON	1 MD 200	31	RESICA	LPKW	451	100	An	inapol	15,	m	0 21	401	
	Sta "Registr		31. Date filed (Month, Day, Year)  JUN 0 5 2006	32. Registra	r's Signa	ture						7				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year **Physician** Novella Dorothy Lawrence 29 2006 11:08a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1645 Cliftview Avenue Baltimore NA 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 5-16-23 Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🕅 F 212-20-9134 Yrs. Director 83 N.C. Usuaf Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itema 23a or 28a-f ehow othar traumatic event, the Medical Examinar must be notified at 1 Xes 2 No Director NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1645 Cliftview Avenue 21218 USA death Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural". or item once, in the contract that the contract th 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Never Married 2☐ Married 1 ☐ Yes 2X No þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usuaf Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Colfege (1-4or 5+) 10th grade Domestic Other Peoples Homes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fred Lawrence Matilda Thatch 19a. Informant's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Lawrence 7414 Nephew Kalton Ct., Pikesville, Md. 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🎇 Burial 2 □ Cremation 3 □ Removal from State King Mem. Pk. 6-3-06 Randallstown, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North 23a. Part1. Enter the disease, or complications that caused the of shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) CUNCE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit o the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. Completed 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1□ Yes 2☑No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3/ No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA After thi funeral 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of Natural 5 Pending investigation Infury within 24 hours after use...
To the Funeral Director: Alt 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D40854 5-31-06 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SILV Kusebera 30) 31. Date fifed (Month, JN 0 5 32. Begistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certificate of De	eath	Reg N	, 200	6 1753
ıysicia Exami	an/	Decedent's Name (First, Middle,Last)  Odell	Lightner		2. Date of Death Month Da May 31, 2006	y Year	3. Time of Death 1157 hrs
		4a. Facility Name (if not institution, give street and number Union Memorial Hospital	,	City, Town, or Location of Death altimore		4c County of Death	1
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ow any		Usual Residence of Decedent  10a State  10b. County	10c. City, Town or Location				10d Inside City Limits 1 X Yes 2 No
r 28a-f she ed at once	Director	Md. NA  10e. Street and Number	Baltimor 10	f. Zip Code		Citizen of What Cou	
or items 23a or 28a-f show must be notified at once.	Funeral Di	2212 W. North Ave.  11. Marital Status  1 Never Married 2 Married Armed Force	s? If Yes, s	21216 specify Cuban, Mexican, Puerto	pecify Yes or No-	JSA 14 Race - Amer White, etc.	can Indian, 8lack,
ural", or i miner mu	ρ	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade or		s $2 \mathbf{X}$ No specify	work done 16	Specify Bla	
Mental Hygiene marked other than "natural", or c event, the Medical Examiner mi	Completed	Elementary/Secondary (0-12) College (1-4 of 12th grade	during most of	of working life. DO NOT use reti anic		Maryland (	Cup
ital Hygien ked other int, the M	Be Con	17. Father's Name (First, Middle, Last)	ghtner	1	(First, Middle, Maid Jordan	len Surname)	
h and Mental 27 is marked imatic event,	Tol	19a. Informant's Name/Relationship (Type, Print)  Carolyn Lightner Wife		dress (Street and Number or I N. North Avenue	e, Baltimo	ore, Md.	21216
Department of Health and Important: If item 27 is in injury or other traumatic		20a Method of Disposition 1 X Burial 2 Cremation 3 Removal from	State 20b. Place of Disposition State Carrison For	Pk.		oc Location - City or andallston Swings Mi	
Departme Importar injury or		Donation 5 Other Specify:  21. Signature of Funeral Service Licenses	22. Name	e and Address of Facility	Balt	timore, Mo E. North	3. 21202
ician dical		27a. Part I. Enfer the disease, or complications that call failure. List only one cause on each line.		node of dying, such as cardiac c	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
			est Injuries				Death
niner		or condition resulting in death)  Due to (or as a condition)					Death
	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	nsequence of):				Death
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ifter death  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a Certifier (Check only one) 2 Medical Examiner in the best of eard manner state and manner stat	nsequence of):  nsequence of):  nsequence of):  8,20b-c per fh come of pregnancy 2 Fetal of 5 Other  eath but not resulting in the under  attent 2 ER/Outpatient 3  Injury 28b. Time of Injury 1057 hrs  f Injury - At home, farm, street, faceted examination and/or investigation,	death 3 Ectopic pregnation (Specify)  26. Place of Death (Check DOA Other4 Nursin  28c Injury at Work? 1 Yes 2 No  actory, office building, etc.  at the time, date and place, and, in my opinion, death occurred.	23e Did tobace  1 Yes 2  24a Was an autopsy performer 1 Yes 2  only one)  ng Home 5 Res  28d Describe how Bicyclist which  28f Location (Street or Town, State 3100 block Fall diduct to the cause(s) at the time, date and	Month  2 No 3 Prol 24b Were au prior to death? No 1 V  Sidence 6 Othe injury occurred struck fixed ob and Number or Ru S Cliff Road, B and manner as star	the cause of death?  Dably 4 Unknown  stopsy findings available completion of cause of  es 2 No  fiect  arai Route Number. City  altimore, MD  ted ie cause(s)
nours after death  neral Director: After this certificate has been signed by the attending physician and  filled in by the funeral director, page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner?  1 Ves 2 No  27. Manner of Death  1 Natural 5 Pending Pregnant in the past 3 Suicide 6 Could not be determined  29a Certifier 1 Certifying Physician: To the best of and manner state 29b. Signature and title of certifier	nsequence of):  nsequence of):  8,20b-c per fh come of pregnancy 2 Fetal of 5 Other  eath but not resulting in the under  eath but not resulting in the under  2 ER/Outpatient 3  Injury 1057 hrs  Injury At home, farm, street, facult of my knowledge, death occurred examination and/or investigation, and	death 3 Ectopic pregnation (Specify)  26. Place of Death (Check DOA Other   Nursing y 28c Injury at Work?  1 Yes 2 No actory, office building, etc.	23e Did tobac  1 Yes 2  24a Was an autopsy performer  1 Yes 2  only one)  ng Home 5 Res  28d Describe how  Bicyclist which  28f Location (Street or Town, State 3100 block Fall did due to the cause(s) at the time, date and	Month  Coco use contribute to  No 3 Prol  24b Were at prior to 4 death?  No 1 Your sidence 6 Other injury occurred struck fixed observants. So Cliff Road, B. and manner as star.	the cause of death?  Dably 4 Unknown  stopsy findings available completion of cause of  es 2 No  fiect  arai Route Number. City  altimore, MD  ted ie cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item #11 Pertale of GRA 6127/106 and Health and Mental Hygiene - State Amend #7 Per FH G856 6/06/06 efficate of Death Registamend Item #19a&b per FH G856 6/05/06 JH Reg. No. 2. Date of Death 3 Time of Death Year Physician Carol Ann Logan June 2006 1842 hrs<sup>M</sup> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 30, 1 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1□M 2X F Months Yrs. 1951 579-70-6492 Maryland Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Odenton Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21113 542 Prince Charles Ave. United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 25 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed XXDivorced white 15 Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Fleet Coordinator Distributing Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Milton Thomas Harris ٥ Helen Lucille Hall 19a Informant's Name/Belationship (Type, Print). Jennifer H. Patrick/daughter 19b Maijing Address (Street and Number or Rural Route Number City of Town, State, Zip Code) 1004 Telford Court, Abingdon, MD 21009 542 Prince Charles Ave., Odenton, MD 21113 Thomas Conley/husband 20b. Place of Disposition (Name of Date 20a Method of Disposition 20c. Location - City or Town, State west Arundel Crematory 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) June 3 2006 Odenton, MD 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.
1411 Annapolis Road, Odenton, MD 21113 21. Signature of Funeral Service Licensee M01427 omenico (modeo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ranco disease or condition resulting in death) Due to (or as a consequence of)

**Physician** /Medical **Examiner** 

attending physician

as the esn

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detached i

page 2 s has

in by the funeral director,

filled within 24 hours a To tha Funaral I

After

Hospital or Attanding death. s after death.

To the

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The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Examiner

Completed by Physician/Medical

Be

Certification: To

Medical

**Funeral** 

Director

77 is marked other than "natural", or Items 23a or 28a-f shov traumatic avant, 11s Madical Examinations the multihad at

al Hygiene.

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ò permit. Page Department of Important: If any injury or

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☑ No
9 🗌 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4☐Pregnant at time of death 9 Unknown

th	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _

23d. Date of delivery Month Day

Part II. Other significant conditions	contributing t	o death b	ut not resulting in	the underlyi	ng cause given in	Part

28a. Da

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

23e	Did tobac	o use con	tribute to the cau	ise of death?
	1 Yes	2 🗆 No	3 Probably	4 Unknow
24a	Wasan	24h	Were autoney fir	adings availab


168 21	7140	3 LI FIU	Dabiy	4 LJOHKHOW
a. Was an autopsy performed?		Were autoprior to co	opsy fin ompletio	dings available
Yes 200		1 Yes	2 - N	0

Year

 examiner?		Н	spital:
Manne of Death			28a.
1 Natural	5 Pending		
2 Accident	investigation	n	

Inpatient 2	ER/Outpatient	3 🗆 [	AOC
te of Injury lonth, Day Year)	28b. Time of Injury	М	280

er: 4 ☐ Nursing H	ome	5 🗌 Res	idence	6 ☐Other (Specify)
y at k?	28d.	Describe	how inju	ry occurred

1 Yes

26. Place of Death (Check only one)

2 DN6

1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pending investigation 6 Could not be determined

	(Month, Day Year)	Injury	М	Work?	2 🗆 N
28e.	Place of Injury - At h building, etc. (Special	ome, farm, stree	et, facto	ory, office	

Oth

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)	1 Certifying PI 2 Medical Exer	thysician: To the best of my knowle miner: On the basis of examination and manner stated.	edge, death occurred at the time, date and place, and due to the nand/or investigation, in my opinion, death occurred at the time	e cause(s) and manner as stated. e, date and place, and due to the cause(s)
29b. Signature and	Wile of certifier		29c. License number	29d. Date signed (Month, Day, Year)
			DM 35 49U	61212006

r	nanner stated.	
		29c. License number
		> 1 / VIGI

29d.	Date	rsigne	d (Month	, Qay,	Year)
			200		,

The second secon	
State	31. Date filed (Month,
Registrar	3011

e Mich 32. Registrar's Signature

			1 - For State Registrar	St			nd / Depa		t of H	ealth a				20	06	175	36	
1	Physici		1. Decedent's Name (First, Middle Diana C. Lin	, Last)								2. Date of De Month May	eath Day 31	′ •	2006	3. Time of 7:40	Death p M	
	/Medical Examiner  4a. Facility Name (If not institution, give street and number)							4b. City,	Town, or	Location o	of Death		4c. County of Death					
**		Montgomery Hospice Casey House								7ille	2411			Mor	ntgome			
	Funeral Director		5. Social Security Number 193–46–7769	6. Sex	2 <b>⊠</b> F	Days	Hours	Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) August 1, 1948 9. Birthplace (State or Foreign Country) Taiwan										
	/land		Usual Residence of Decedent  10a. State 10b. County			10c. C	ity, Town or Lo	cation							16	Od. Inside Ci	ty Limits	
	a-f sh	Funeral Director	Maryland Montg	omery			Rock	ville	е							1 🛚 Yes	2 🗍 No	
)36	h with the		10e. Street and Number  2 Scotch Mist Court					Code 20854	+			10g. Citizen of What Country? United States						
	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural" or items 23s or 28s-f show event, the Medical Examinar must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1	1 □Yes 2 X No			Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.     1 □ Yes 2 № No Specify:				ecify Yes or No Rican, etc.)	0-	14. Ra Bla Speci				
21215-0036	in 72 hou "nature solice! E	Completed	15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						16b. Kind of Business/Industry					
	d with giana.	omo	Elementary/Secondary (0-12)	С	ollege (1 5+	-4or 5+)	Resea						Res	ear	ch C	ompany	r	
0	should be filed within 72 h and Mental Hygiene. a marked other than "natu umatic event, Ine Medica	To Be C	17. Father's Name (First, Middle, Kim Ling Liu	Last)							ng Yi	(First, Middle U	, Maiden	Suma	тө)			
	es 1 and 2 should to the stand and Ment of Health and Ment I I tem 27 is marked to the traumatic expenses to the traumatic expenses.		19a Informant's Name/Relationsh Steve C. Lin /									n Route Numb						
w	permit. Pages 1 a Department of He Important: If Item any injury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation  4 ☐ Donation 5 ☐ Other (S)  21. Signature of Funeral Service is	pecify)	al from S	Jiaie	Place of Dispo cemetery, crem ntgomery	Cremat	torium	Inc	2006 Rob	ert A.	Bet!	neso hre	v Fun	rylan	d ome/	
ñ	Deg and a special series		) Let	4		M014	433 Po	ckvil	lle,	Inc. Maryl	300 Land	West M 20850-	2805	ome	ry Av	e-ucre		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line.  Lung Cancer  Due to (or as a consequence of):									Approximate Interval Betw Onset and D	veen			
V	ate be executed hysicien and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	Due to (or as a consequence of):  Due to (or as a consequence of):													
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	the death certificat by the attending phy ached for use as th	hysiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	11	11 Live birth 21 Fefal death 31 Ectopic pregnancy										Date of delivery Month Day Year			
rds, r	w requires that the de been signed by the should be detached	by P	Part II. Other significant conditio	ons contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute I										cause of de				
L Kec	The larate has	Completed	10								perfo	Was an sutopsy performed? es 2 ☒ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No				vailable use of		
Phy This	this raid	ation; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident Investig	28	26. Place of Death (Check only one)    Check on In One													
OIVIS N	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral or the funeral	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (3 City or Tou	Location (Street and Number or Rural Route Number, City or Town, State)					
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier  (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.												ted. the cause(s)			
	To t Com	2	29b. Signature and vitle of certifier		29c. License number D35635						29d. Date signed (Month, Day, Year)  June 1, 2006							
	16		30. Name and address of perso was Joseph Kaplan M	.D. 6	001	Muncasi	ter Mil	1 Roa		lockvi	ille.	, Maryl	and	208	55			
	Sta Registr	te ar	31. Date filed (Month, Pay, Year)	5 2008	32. Re	estrar's Signa	ature	back	,									

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

MABEL

ORIGINAL

		•	For	State of M		d / Depa		Health :	and M	ental Hy	giene	onne	175	32
			Registrar  1. Decedent's Name (First, Middle, Las	t)			incate of	Dealii		2. Date of De	Reg. No.	-000	3. Time of D	Death
	Physicia	an	James H. Litz	•						June	2 Day	2006	4:10a	
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town,	or Location		o arre		County of Dear		
	Examin	er	Stella Maris	•			Timo	nium			В	altimo	ore	
	Funeral		Social Security Number     6. Security Number		e (In yrs. i	ast birthday)	If Under 1 Year	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da	th Vone	9. Bin	thplace (State or ountry)	Foreign
	Director		214-56-2091	M 2□F	85	Yrs.	Months Days	Hours		10-16-		0 Ba	Ltimore	
	pu ,		Usual Residence of Decedent  10a. State 10b. County		100 Cib	y, Town or Lo							10d. Inside City	. Limito
	anyla shov	-	MD Balti	more		owson	ocation						1 Tyes	
	28a-f	ecto	10e. Street and Number		<u> </u>		10f. Zip Code				10a Citis	en of What Co	l	
	a or	ă	1812 Landrake	beag			2120	4			USA	en or writat or	outiny:	
	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show colcat Examinat must be notified at	Completed by Funeral Director	11. Marital Status	12. Was Decedent	Ever in U	S 13			igin? (Spe	ecify Yes or No	)-	4. Race - Ame	erican Indian.	
	iter d	F	1 ☑ Never Married 2 ☐ Married	Armed Forces	,	-	Was Decedent of I If Yes, specify Cub			Rican, etc.)		Black, Whit	te, etc.	
036	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2X No	Specify	:			Specify: Wh	irce	
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pu	be fill H doth	Be	17. Father's Name (First, Middle, Last)							(First, Middle tia We		Sumame)		
yla	should be filed withir nd Mental Hygiene, marked other then imatic event, Ita Ma	7	Frank Litz											
Mai	CA CO		19a. Informant's Name/Relationship (19a) Colbourne Hars		SIII		ng Address <i>(Stree</i> Straffa							
a)	1 and Health em 27 Ither tr		20a. Method of Disposition	iler	20b. P		osition (Name of matory or other pla			ate		ation - City or		
ē	ages int of t: If It		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State		<sub>emetery, crei</sub> udon		ice)	6/ <b>7</b> /	2006	Bal	timor	e, MD	
Baltimore, Maryland 21215-0036	permit. Pages 1 and Depertment of Heal Important: If Item 2 eny injury or other once.	0 1	21. Signature of Funeral Service Licen		1-0		2. Name and Addr	ess of Facil	ity To	scoph	N 7	annin	o Jr. I	7H
8	Depe Impo eny i		Maria M2	anne	1		63 S. C		UC					
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	1	d the death								Approximate Interval Betw	
	Physician		tmmediate Cause (Final disease or condition		tro								Onset and De	
	/Medical		resulting in death)	a. Due to (or as										
	Examiner		Sequentially list conditions	b										
	₽ ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Ente. Underlying Cause (Disease or injury	Due to (or as	a consequ	uence of):								
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as										
760,	te be execul ysicien end ie burial-trar		rooming in coain, each	Due to (or as	a consequ	uence di):								
687	eath certificate be executed ettending physicien end for use as the bunal-transit	dical		d								-		
9 ×	certificat nding phy use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregna	incv						3d. Date of de	launa.	
Вох	death e e etten ad for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	I death 3	Ectopic pregnance Other (specify)	Эy			-	Month		ear
P.O.	the ty the true	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown			., ,, ,,							
	res that igned b be deta	by P	Part II. Other significant conditions of	ontributing to death I	out not resi	ulting in the u	inderlying cause g	ven in Part	I.	23e. Did t	obacco u	se contribute to	the cause of de	ath?
rds	w requires that been signed b should be deta	<b>P</b>								10	Yes 2	No 3□Pi	robably 4 🗖 Ur	nknown
00	> 0 70	Completed								24a. Was		24b. Were au	utopsy findings as completion of car	vailable
Ä	The law ate hes page 2:	E								auto perfo 1 ☐ Yes	ormed? 2UANo	death?	completion of call 2 □ No	use or
ita	siclen: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	100 1000				26. Plac	e of Death	Check only				
<u>_</u>	Physiclen: r this certific ral director,	10	1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpati	ent 2	ER/Outpatie	nt 3 DOA Ot	her: 4 🗆 N	ursing Hoi	me 5 🗌 Resi	dence 6	Other (Spe	city) HOSP	ice
u	er er		27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury ay Year)	28b. Time o Injury	Wo	ork?		28d. Describe	how injury	occurred		
sio	Attending r death. ector; After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be					]Yes 2[		004 1 1	· · ·		10 . 11 .	
Division of Vital Records,	or A	Certification:	4 Homicide determined	building, e	tc. (Specif	y)	reet, factory, office			City or To	wn, State)	I NUMBER OF A	ural Route Numb	θľ,
أسيا	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 Certifying Ph	ysician: To the best	of my kno	wiedge, deat	h occurred at the t	me, date a	nd place.	and due to the	cause(s)	and manner as	s stated	
	Ho:	edical		niner: On the basis of and manner s	of examina	tion and/or in	vestigation, in my	opinion, de	ath occurr	ed at the time,	date and	place, and due	e to the cause(s)	
	To th Withir To th compl	Me	29b. Signature and title of certifier					se number				signed (Mont		
	/		1	-			D	437	25		Ju	ne à	2,200	6
. 1	V		30. Name and address of person who	completed cause of	death (Iten	23a) (Type,	Print) 22	00	Du	lane	u L	aller	RD	
4			Taria Mal	mood,	M.D	)		nan	1111	m	MT	)	2,200 RD 1093	<u> </u>
	Sta Regist		31. Date filed (Month, Day, Year) JUN 0 5 200		rar's Signa	iture	rolls			,	,	X	1075	

@ 4:10AM

June 2, 2006

James H.

			1 - State Registrar	State of Maryland		rtificate of		Mental Hyg	giene Reg. No. 2 () ()	6 17539
	Physici	an	Decedent's Name (First, Middle, Last,	)				2. Date of Dea Month	Day Ye	3. Time of Death
	/Media	al	John L. McLaren  4a. Fecility Name (If not institution, give	atmat and number		4b. City, Town, o	r Location of Do	DUNE	4c. County of I	06 0337 <sup>M</sup>
	Examir	er	Union Memorial He			Balti		auı	N/A	Death
	Funeral		5. Social Security Number 6. Sec	x 7. Age (In yrs. I	last birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of Birt		Birthplace (State or Foreign
	Director		219-32-4840	<b>X</b> M 2□ F 70	Yrs.	Months Days	Hours Mi	rs. 8. Date of Birt n. (Month, Da 10/04/1	935	eorgia
	and **		Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits
	Maryl -f aho	ţō	MD N/A		Baltin	nore				1 ☐ Yes 2 ☐ No
	r 28a	lrec	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	it Country?
	23a o	Funeral Director	830 West 40th St	reet		2121	1		United S	States
	r dea	ne	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of H	lispanic Origin? an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		American Indian, White, etc.
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Married 4 ☐ Divorced	1 ∑Yes 2 ☐ No If Yes, Give Year or Dates:		1□Yes 21xxNo	Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or liems 23e or 28e-f ahow he Madical Exeminer must be notified at	ted	15. Decedent's Edu	vcation	16a. Dece	dent's Usual Occup	ation		16b. Kind of Busin	ess/Industry
215	thin 7.	Completed	(Specify only highest grad	College (1-4or 5+)		kind of work done DO NOT use retired		vorking		
2	led wi ygjen her th	S	12	4	Eng:	ineer/Dir			ent Engi	neering
and	ntat H	Be	17. Father's Name (First, Middle, Last)	MaT aron				lame (First, Middle,	маюн Sumame) e Hare McI	aron
Maryland	should nd Me mark matic	၉	John L. Malcolm  19a. Informant's Name/Relationship (Ty		19b. Mailir	ng Address (Street			er, City or Town, Sta	
S .	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: If items 23a or 28a-f ahow Important: If items 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic avent, the Madical Examiner must be notified at Angle.		Shannon C. McLare			-			•	ark, FL 33309
J.e.	of Hee	li	20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of matory or other place		Date	20c. Location - City	
<u>=</u>	Page ment of ant: If		1 Dopation 5 Other (Specify)	Removal from State		n Cemeter		6/06/2005	Baltimo	ore, MD.
Baltimore,	permit. Departr Imports any inj		1. Signuture of Funeral Service Lisens	өө " О	22	2. Name and Addre	ss of Facility H	ubbard Fu	neral Hom	ne, Inc.
	20 E = 0		A 700							ryland 21229
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of immediate Cause (Final	ne cause on each line.	n. Do not ent	er the mode or dylr	C 1		rest,	Approximate Interval Between Onset and Death
F	Physician /Medical		disease or condition resulting in death)	a. Due to (or as alconsequ	tre	Heart	faile	ne		12 days
1	Examiner			. Photographic	Dence of).	•••	1			LWK
		ner	if any, leading to immediate cause. Enter Underlying	Due t (or as a consequ	uence of):					
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c					_	
760,	te be executed ysiclen and le burial-transit	cai E	is suiting in county cust	Due to (or as a consequ	uence on:					
	# × 9									
Box (	in g	a)		d.						
	pul nug	n/Me	IF FEMALE: 23b. Was decedent pregnant	d. 23c. If yes, outcome of pregna	ancy	7			23d. Date of	f delivery
	death ce	ician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	ancy	□Ectopic pregnancy □ Other (specify)	,		23d. Date of Month	f delivery Day Year
P.O. B	at the death ce I by the attendi etached for use	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Preg <i>nan</i> t at time of de 9 ☐ U <i>n</i> known	ancy I death 3 (eath 5 (	Other (specify)			Month	Day Year
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l Records, P.O. B	v requii been s should		23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Preg <i>nan</i> t at time of de 9 ☐ U <i>n</i> known	ancy I death 3 (eath 5 (	Other (specify)		1 ☐ Y 24a. Was autop perfor	Month  Obacco use contribu  Yes 2 No 3 and 24b. Were sy prior deat	Day Year  te to the cause of death?  Probably 4DUnknown  e autopsy findings available to completion of cause of
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			For State Registrar	State of Mai	-	artment of H			giene 2 (	106	17540
			Decedent's Name (First, Middle, I	last)				2. Date of Dea	ıth		3. Time of Death
	Physicia		Virginia			McC	all	Month	30 2	Year Lack	8:00 AM
)	/Medic Examin		4a. Facility Name (If not institution, s	ive street and number)		4b. City, Town, or			4c. County		
			The Johns Hopki	Ne Hospital	/		nore (	ity		NΑ	
	Funeral		.,	. Sex 7. Age 1	(In yrs. last birthday	Months Days	If Under 24 Hrs. Hours Min.	(Month, Day	/, Year)	9. Birthp Cour	
	Director	-	213-14-9812 Usual Residence of Decedent	75	91 ''s.			1-29-	-15		Md.
	land	-	10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
	Mary	ţ	Md.	N A	I	Baltimore					1 XYes 2 □ No
	or 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V		ntry?
	death with the Maryland ms 23a or 28a-f ahow rintert be routiled at		1914 N. Wolf	e Street		2121				USA	
	be filed within 72 hours after death with the Marylan Hygiene. A let Hygiene. I with the "natural", or Itams 23a or 28a-f show other than "natural", or Itams 23a or 28a-f show event, tra Medical Exacular must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 □ Yes 2 2 No If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (S in, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	14. Rac Blac Specify	e - Americk, White, Black	
Ş	72 ho	ted	15. Decedent's (Specify only highest)	Education	16a. Dece	edent's Usual Occup	ation during most of wo	rkina	16b. Kind of B	usiness/In	dustry
Ž	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	life.	e kind of work done of DO NOT use retired	()	9	Dood	Cov	rriae
7	filed w Hygier other th	ဝိ	6th grade  17. Father's Name (First, Middle, La	net)		Laborer	19. Mothor's Nor	ne (First, Middle,		l Ser	. vice
⊆		Be		51/	Fleet			ottie	Waldell Suman	Hi]	17
Ž	should and Men a marke umatic	ဥ	Andrew  19a. Informant's Name/Relationship	(Type, Print)		ing Address (Street			r, City or Town,		
	27 tra		Monica McCall	Granddau		932 Sene			-		
ē,	s 1 ar		20a. Method of Disposition		20b. Place of Disp	osition (Name of ematory or other place	ee)	Date	20c. Location -	City or To	own, State
Ē	Pages Tent of Int: If It		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			at. Mem.1	'- I	5-06	Laur	el, N	١d.
Baltimore,	permit. Page Department of Important: If any injury of once.		21. Signature of Funeral Service Lie	ensee	2	2. Name and Addres	1		imore, l E. Nor		21202 Ave.
			23a. Part1. Enter the disease, or or	omplications that caused t	he death. Do not or						Approximate
	Physician		shock, or heart failure. List or Immediate Cause (Final	ly one cause on each line		•					Interval Between Onset and Death 48 hours
<i>)</i>	/Medical		disease or condition resulting in death)	Due to (or as a	consequence of):						78 110 cm
	Examiner		Sequentially list conditions,	b							
	ν <del>π</del>	Iner	cause. Enter Underlying Cause (Disease or injury	Directo (or es a	consequence of)						
<b>)</b>	ecute and trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):						
8760,	icate be executed physician and s the burial-transit	al E		200 (0) (0) 03 0	consequence on.						
287	icate phys s the	edical		d.							
×	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		Π <b>σ</b>			23d. Da	te of deliv	егу
m m	death	lcla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify) _			Mo	onth	Day Year
о <u>.</u>	at the de by the a stached	h y	9 🗆 Unknown								
Records, I	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ρ	Part II. Other significant condition	s contributing to death but	t not resulting in the	underlying cause giv	en in Part I.	23e. Did to	40		he cause of death?
000	aw requir s been si 2 should l	Completed						24a. Was	an 24b.	Were auto	opsy findings available impletion of cause of
	The lay	E O						autop perfor 1 ☐ Yes	med?	prior to co death? 1 □ Yes	
ta	ian: rtifica ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only o	-,-		
<u> </u>	Physician: r this certifica ral director, I	ဥ	1 Yes 2(XNo	Hospital: 1 2 inpatien	t 2 ER/Outpatie		4   Nursing r	lome 5□Resid	ence 6 □Oth	er (Specif	fy)
Division of Vital	ing P	0	27. Manner of Death 1 VONatural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	Wor		28d. Describe h	ow injury occur	red	
Sic	Attending or death. ector: After by the fune	cat	2 Accident investiga 3 Suicide 6 Could no	t be 200 Blace of Injur	ry - At home, farm, s		Yes 2 □ No	28f Location (S	Street and Numb	er or Run	al Route Number,
<u>≥</u>	after after Direct din by	Certification:	4 ☐ Homicide determin	building, etc.	(Specify)	tiest, lactory, onlos		City or Tow	n, State)	07 07 71010	ar riodio ivombor,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funaral Director: After this certificate h completely filled in by the funeral director, page	Medical C		Physician: To the best of kaminer: On the basis of and manner state	examination and/or i						
	o the o the omple	Mec	29b. Signature and title of sertifier	and manner s(a)	<del>o</del> u.	29c. Licens	e number		29d. Date signe	d (Month,	Day, Year)
	⊢ ≯ ⊢ ŏ		16/	M. A. 10 -1	District	Res	- 000	)	May	30.	2.006
	1		30. Name and address of person w	ho completed cause of de	ath (Item 23a) (Type					101	
	7		EVAN LIPSON T.	he Tunis Hopi		tal, 600 1	Wich Well	Street 6	Elthouse,	Mari	eland 21287
	Sta		31. Date filed (Month, Day, Year)	32 Registrar	r's Signature			• ,		7	
	Regist	ar	JUN 0 5 2	UU6 Marce	H. K.	and I					

DHMH 17 Rev 1/2001

ORIGINAL

06-03410 Patricia Matthews

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 2006 17541 Certificate of Death Registrar Reg No 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Day May 20, 2006 **Medical Examiner** Patricia Matthews 0145 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1220 West North Avenue Apt. D NA Baltimore **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. B. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Director Days Hours Min 212-56-4778 1 M 2 X F 07-16-1950 Md. Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d Inside City Limits s 23a or 28a-f show a 1 X Yes 2 No Md. NA hours after death with the Maryland Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1100 Ramblewood Rd. Apt. 21239 USA Funeral 11. Marital Status items 2 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, Armed Forces 1 Never Married 2 Married White, etc. Yes 2 X No Widowed If Yes, Give Year Divorced 1 Yes 2 X No specify traumatic event, the Medical Examiner Black Specify: ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Popartment of Health and Mental Hygiene. Important: If item 27 is marked other than " College (1-4 or 5+) 12th grade Domestic Other People Homes 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) William Matthews Marv Α. Giles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tanyanika Spencer 1100 Ramblewood Rd. Apt. B, Balto., Md. Daughter 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State or other crematory or other place) Burial 2 Cremation 3 Removal from State 6-2-06 Greenmount Cem. Baltimore, Md. Donation 5 Other Specify 21 Signature of Funeral Service Licen 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave. 23a. Part I. Enter the disease, of complications that caused the death to enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical Immediate Cause (Final disease Hypertensive cardiovascular disease -Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Finneral Director. and trar Physician/Medical item#23a,27,perME,g856,6/8/06 TT X UNPENDED g physician a AMENDED 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Day past 12 months? Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown Unknown been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other<sub>4</sub> Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✓ Other: Scene 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred A 24 hours after deau...
he Fineral Director: A' 1 X Natural Pendina 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 2Bf. Location (Street and Number or Rural Route Number, City Could not be Suicide (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. May 20, 2006 30. Name and address of person who completed cause of death (Item 23a) Pamela Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signature JUN 0 5 Registra

ORIGINAL

		- State Registrar Amend #17 Pe  1. Decedent's Name (First, Middle, Last)	ar tur (202)	0-0/0	9/ <b>U</b> 6 3	<u>)H</u>		1	2. Date of Dea	Reg. No		3. Time of Death	_
Physicia /Medic		Betty Ann Mur:	ray					]	May 30	), Da	2006 <sup>Year</sup>	6:14 P	М
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uneral irector		219-22-5770	M 2DF	82		Months Days	Hours	4.4.	B. Date of Birth (Month, Day Jan •	(4°)	1924	hplace (State or Forei MD	gn
>		Usual Residence of Decedent		10. 00. 7									
ahov a d	2	10a. State 10b. County		10c. City, To		tion						10d. Inside City Limit	
r 28a-f ahow notified at	Funeral Director	MD Baltimore  10e. Street and Number		Tows	son	10f. Zip Code				100 Cit	izen of What Co		
3a or	٥	24 B Allenbrooke	Crt			21204	<b>'</b> .			rog. Cit	USA	untry?	
T P	nera		12. Was Decedent Ev	ver in U.S.	13. Wa	s Decedent of H	<del> </del>	n? (Spec	ify Yes or No-		14. Race - Ame		
mine	/Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	0	i	es, specny Cuba ]Yes 21∑ No		Puerto Hi	ican, etc.)		Black, White	e, etc.	
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man l		19a. Informant's Name/Relationship (Typ	,								r Town, State, Z		
other t		Kimberly Baker - 1 20a. Method of Disposition	Daugnter					d Ba.			laryland		_
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any inju		HM LCh	Pama	,	C.	nemation	Soci	ety o	of Mary	lan	d, Inc.	and 21228	
		23a. Pari 1. Enter the disease, or complic	cations that caused the	he death. D	o not enter t	the mode of dying	g, such as ca	ardiac or i	respiratory arr	est,	, Maryi	Approximate	_
cian		shock, or heart failure. List only on Immediate Cause (Final disease or condition		_	Car	Acono		<b>b</b>				Interval Between Onset and Death	
edical		resulting in death)	Due to (or as a	consequenc	e of):	don	9000	27				Years	
niner		Sequentially list conditions, b											
sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequenc	e of):								
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for use as	Physician/Med	230. Was decedent pregnant	3c. If yes, outcome of 1□Live birth 2		ith 3∏Eo	topic pregnancy				:	23d. Date of deliv	very	
tached fo	Sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐ Pregnant at tiv			ther (specify)					Month	Day Year	
			tributing to death but	net seculties	- i- +	47	1.0.11		00 Dive	-1			-
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era		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day )	28b	. Time of Injury	28c. Injury Work	at	286	d. Describe ho	w injur	y occurred	"III VOIT LE	
he fu	atic	2 Accident investigation					res 2 □ No	,					
n by t	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, (Specify)	farm, street,	factory, office		281	Location (St. City or Town	reet and	d Number or Rur	ral Route Number,	
		20- Continu	li Tarini Tarini Tarini										
etely t	Medicai	29a. Certifier (Check only one) Certifying Physical Examin	ician: To the best of er: On the basis of e and manner state	xamination a	ge, death oc and/or invest	curred at the tim tigation, in my op	e, date and pointion, death	occurred	d due to the ca at the time, da	ause(s) ate and	and manner as a place, and due to	stated. to the cause(s)	
omple	Me	29b. Signature and title of certifier	and manner state	-		29c. License	number		25	9d. Date	e signed (Month,	, Day, Year)	_
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		30. Name and address of person who cor		ith (item 23a	ı) (Type, Prir	nt)	,		2		mo 2		
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2	-	/ 10211	32. Registrar				-	•		-		/	

			For State Registrer	State	of Mar	-	partment of learning		nd Mer		iene g, No. 20	06	17543
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	Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. last birthd	ay) If Under 1 Year	If Under 24	_	Date of Birth	11011	9. Birthp	place (State or Foreign htry)
	Director		219-48-7957	1 XM 2□ F		59 Yrs	Months Days	Hours	Min.	Date of Birth (Month, Day, UL 2,	1946 V	Vashi	ington, DC
			Usual Residence of Decedent										
	hours after deeth with the Maryland turel', or Items 23a or 28e-f ehow al Examiner must be notified at		10a. State 10b. County		1	10c. City, Town o	Location					1	Od. Inside City Limits
	Ma 	Director	Maryland Mont	tgomery			Sil	ver Sp	ring				1 ☐ Yes 2X No
	7 28 room	ire	10e. Street and Number				10f. Zip Code			1	0g. Citizen of W	hat Cour	ntry?
	13a o	D E	722 Sligo Av	zenije				20910			US	SA	
	be filed within 72 hours after deeth with the Marylan Ital Hygiene. Id other then "naturel", or Items 23e or 28e-1 ehow event. The Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Dec	cedent Ev	rer in U.S. 1	Was Decedent of If Yes, specify Cub	Hispanic Origin	? (Specify	Yes or No-	14. Race	- Americ	an Indian,
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3	ol', o	by	3 Widowed 4 Divorced	If Yes, G Year or I			1 ☐ Yes 2 ☐ No	Specify:			Specify:	Wh:	ite
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9	il Hygi other	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's	Name (Fil	rst, Middle, N	Maiden Sumame	9)	
yland	should be nd Mental marked c	To E	Lawrenc	e MacDo	na1	d			F	rance	s Quir	n	
2	and N		19a. Informant's Name/Relations	nip (Type, Print)		19b. M	ailing Address (Stree	t and Number o			-		Code)
Mar	s 1 and 2 should f Health and Men Item 27 le marke other treumatic		Robin F. Mod	re/Wife	2	7	22 Sligo	Aven	ue	Silve	r Spri	nø.	MD 20910
ē,	Hear Hear tem othe		20a. Method of Disposition	, LC / WIIC	3	20b. Place of Di	sposition (Name of		Date		20c. Location - 0		
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n	permit. Page Department Important: I Important: I eny Injury o		Eghon A K	1 nl			22. Name and Address		Crema	ation	Society	oi	MD, Inc.
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			shock, or heart failure. List	only one cause on	each line.	·	enter the mode of dy	ng, such as car	rdiac or res	spiratory arre	351,		Interval Between Onset and Death
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S	w requires that the de been signed by the should be detached	hys	9 🗌 Unknown	9L 011k1	TOWN								
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<u> </u>	death. ctor: A y the fu	ica	3 Suicide 6 Could r	not be 200 Place	o of Injun	( At home form	street, factory, office	103 2 100		Location /St	rant and Mumba	r os Puro	l Route Number,
<u>&gt;</u>	or At after of Direction by	Certification:	4 Homicide determ	ined build	ding, etc.	(Specify)	street, ractory, office		201.	City or Town	, State)	i oi nuia	noute Number,
_	To the Hospitel or Attending within 24 hours after death.  To the Funers! Director: After completely filled in by the fune		200 Cartifies 4 To Cartifyin	a Dhusiaian. Ta th					1				
	Hos 24 ho Fun Fun tety f	Medical	29a. Certifier 1 Certifyin (Check only 2 Medical	Examiner: On the i	Dasis of e	xamination and/o	eath occurred at the transfer investigation, in my	me, date and p opinion, death o	occurred a	due to the ca t the time, da	use(s) and man ite and place, ai	iner as st nd due to	ated. the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier		nner state	id.	29c. Licen	se number		-10	d Data signed	/Month	Day Vansl
	T W O		255. Oignature and title of cartine		/						d. Date signed		
							D35	635			June 3	, 2	006
	10		30. Name and address of person	•									
	_		Joseph Kapla				ster Mill	Road Ro	ockvi.	lle, M	D 20855		
	Sta		31. Date filed (Month, Day, Year)	NE S	Hegistrar'	s Signature	- 40						
1	Registr	ar	JUN 0.5 20	Ub J	382	it ans	and I						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Stephen Shane McNaney 2 3:00 June 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death

Days

Months

10f. Zip Code

7. Age (In yrs. last birthday)

49

10c. City, Town or Location

Catonsville If Under 1 Year | If Under 24 Hrs.

Catonsville

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

21228

1 ☐ Yes 2 X No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Hours

8. Date of Birth (Month, Day, Year)

APR 2,

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland nan "natural", or Itama 23a or 28a-f ahow • Medical Examinar must be notified at Baltimore, Maryland 21215-0036

1 - For State Registrar

10a. State

Maryland

11. Marital Status

10e. Street and Number

2101 Devere Lane

10b. County

2101 Devere Lane

1 Never Married 2 Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

Baltimore

15. Decedent's Education (Specify only highest grade completed)

McChin Win Myrint

N 0 5 2006

Khin Win Myint, M.D

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

10XM 2□ F

12. Was Decedent Ever in U.S Armed Forces?

1 ☐ Yes 2 ②No If Yes, Give Year or Dates:

College (1-4or 5+)

5. Social Security Number

216-68-6009

Usual Residence of Decedent

**Physician** 

/Medical

Examiner

Director

npieted by Funeral

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the entending the funeral director of the funeral director. Division of Vital Records, P.O. Box 68760,

S	12			Carpente	er			Constru	ction
a	17. Father's Name (First, Middle, Las	1)			18. Mot	her's Name (Firs	t, Middle, Maid	den Sumame)	
To B	John B. Mc	Naney, Sr.				Patricia	a Hayn	es	
	19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Address	(Street and Num	ber or Rural Rou	te Number, Ci	ty or Town, State,	Zip Code)
	Linda McNaney/Wi			101 Deve		Catons	sville,	MD 212	28
	20a. Method of Disposition	2	Ob. Place of cemeters	Disposition (Name, crematory or other	e of her place)	Date	20c	. Location - City o	Town, State
	1 🛱 Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Spec	_Inditioval from State		od Cemet		6/7/06		Baltimo	re, MD
	21. Signatura Funeral Service Oce	nsee .		22. Name and	Address of Fac	ality MacNa	abb Fu	neral I	lome,
	Edward A. Gr	egorchik		301 Fr	rederick	Road Ca	atonsvi	lle, MD	<u> 21228</u>
	23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the one cause on each line.	death. Don	ot enter the mode	of dying, such a	as cardiac or resp	oratory arrest,		Approxir
	Immediate Cause (Final disease or condition	END S	TAGI	E CIA	BHOSE	VIS 08	THE	LIVER	Onset a
	resulting in death)	Due to (or as a co		f):					
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	cause. Enter Underlying Cause (Disease or injury that initiated events	0.		301D					
Examin	resulting in death) Last	Due to (or as a co	nsequence o	f):					
by Physician/Medical	•	d							
Med	IF FEMALE:								
217	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐		3 ☐Ectopic pre	gnancy			23d. Date of de Month	elivery Day
Sici	1 Yes 2 No	4☐Pregnant at time 9☐ Unknown	e of death	5 Other (spe	ecify)			Worter	Duy
P.	Part II. Other significant conditions	contributing to death but n	ot reculting in	the undertains on	use swee in Per	+1	3a Did tobacc	co use contribute	to the cause
	Part II. Other significant conditions	contributing to death out in	or resulting in	the underlying ca	use given in Far	(1,		2 No 3 ₽	
ed							Tes	2 UNO 3 UF	. Suduly 4
Completed						2	4a. Was an autopsy	prior to	ulopsy findir completion
ပ္ပ						1	performed ☐ Yes 2	No death?	s 2□No
Be	25. Was case referred to medical examiner?	11				ce of Death (Che	-		
2	1 ☐ Yes 2 ☑ No			patient 3 DO				6 □Other (Sp.	ecify)
ation:	27. Manner of Death  1 In Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	par) 28b. T	me of 28 jury M	3c. Injury at Work? 1 ☐ Yes 2 {		escribe how i	njury occurred	
Certification:	3 ☐ Suicide 6 ☐ Could not determined		At home, far Specify)	m, street, factory,	office		ocation (Street lity or Town, Si	t and Number or F tate)	lural Route N
Medical (	29a. Certifier 1 ▼ Certifying P (Check only 2 ■ Medical Exa	hysician: To the best of m miner: On the basis of exa and manner stated	amination and	death occurred a Vor investigation,	it the time, date in my opinion, d	and place, and death occurred at	ue to the cause the time, date	e(s) and manner a and place, and du	s stated. e to the cau:
Me	29h Signature and title of certifier			29c	License numbe	r	29d.	Date signed (Mor	th. Day. Yes

Baltimore, MD ineral Home, P.A. .lle, MD 21228 Approximate Interval Between Onset and Death LIVER 23d. Date of delivery Month Year Day co use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were aulopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No d2 1 No 6 ☐Other (Specify) injury occurred at and Number or Rural Route Number, State) e(s) and manner as stated. and place, and due to the cause(s) Date signed (Month, Day, Year) D0055 301 June 2, 2006 6701 N. Charles Street, Ste. 5100, Towson, MD

Baltimore

10g. Citizen of What Country?

Specify:

USA

16b. Kind of Business/Industry

Construction

Race - American Indian, Black, White, etc.

White

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 X No

Maryland

State Registrar

	-	For State Registrar	State of M	laryland	-			ealth a	and M		Reg. No	7111	16	1751	15
Physici /Medic	an ai	1. Decedent's Name (First, Middle, La					Pres			2. Date of De Month May	De 3		100 lo	3. Time of Dea	ıth M
Examin	C1	4a. Facility Name (If not institution, give Softes Hap Kills 1	Bay view	r) Metical age (In yrs. las				Location of Lmore		8. Date of Bir	th		Α	lace (State or Fo	reio
Funeral Director		224–50–3695 Usual Residence of Decedent	□M 2/X F	69	Yrs.	Months		Hours	Min.	(Month, Da 12–1	ay, Year,	)	Coun	N.C.	, 0, 9,
e Marylanda-febow	ctor	Md. NA		10c. City,	Town or Lo Balt		9						1	0d. Inside City Li M☐ Yes 2	
th with th	ral Dire	10e. Street and Number 4703 Parkside Gar	den Way	Apt. B		10f. Zip	212					tizen of Wr USA			
be filed within 72 hours after death with the Maryland tal Hygiene. Indocther then "natural", or Items 23a or 28a-f ehow event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 Tyes 2 1 If Yes, Give Year or Dates	s? ¶No		Vas Dece f Yes, spe		spanic Orion, Mexican Specify:	gin? (Spo , Puerto	ecify Yes or No Rican, etc.)	)-	14. Race Black, Specify:	White,		
within 72 ho iene. rthen "natur the Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12th grade			16a. Deced (Give life. L	kind of wo	ork done o	luring most	of work	ing		ind of Bus			
should be filed ind Mental Hygi marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last Fred	)	Carrir	ngton			18. Mothe	r's Name	a (First, Middle	, Maidei	n Sumame,	U,	NK	
od 2 suith ar 27 le		19a. Informant's Name/Relationship ( Billy Carrington			6 K	itri	dge (		Balt	imore,	Md.	211	33		
		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		e cen	ce of Dispo netery, cren . Carn	natory or a	other plac		6-6-	Oate		ocation - C ndalk			
permit. Page Department of Importent: if eny Injury or		21. Signature of Funeral Service Lice	nsee	Tro				s of Facilit		Balti 1101		e, Md Nort		1202 e.	
Physician /Medical Examiner	her	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying	a. Strok	line.	ince of):									Interval Betwee Onset and Deal	th 15
death certificate be executed e attending physicien and nd for use as the burial-transit	dical Examiner	Cause (Disease or injury that intiated events resulting in death) Last	101	tes es a conseque tension									g g	en year Ten year	7
death certifi e attending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		2 Fetal d at time of dea	eath 3	]Ectopic p ] Other (s)						23d. Date Monti		ory Day Year	
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Physician; this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	-55			Othe			n (Check only					
Attending Physic death, ector: After this by the funeral di	atlon: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of fr (Month, L		R/Outpatien 8b. Time of Injury		28c. fnjun Worl	4 □ Nu / at /? Yes 2 □		me 5 Resi 28d. Describe				/)	
는 를 들 드	Certification:	3 Suicide 6 Could not to determined	289. Place of	Injury - At hom etc. (Specify)	ne, farm, str	eet, factor	ry, office			28f. Location ( City or To			or Rura	l Route Number,	
the Hospital in 24 hours a the Funeral optately filled	edical	(Check only 2 Medical Exa	hysicien: To the beariner: On the basis and manner	of examination	ledge, death on and/or in	vestigation	n, in my op	oinion, dea	d place, th occuri	and due to the ed at the time,	date an	d place, an	d due to	the cause(s)	
To the within 2 To the complet	Z	29b. Signature and title of certifier  Michael Levy	, M.D.				c. License	o number Øøø				ate signed (			
4	ate	30. Name and address of person who	completed cause o		treet,		ltino	e, N	lary l	and, 2	.128	77			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 31 2006 5:45 P.M IRVIN SCOTT POEHLMAN May 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 ☐ F Maryland 81 Yrs. 218-12-0120 Oct. 6, 1924 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Glen Arm Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11630 Glen Arm Road 21057 Unit 18 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 4 years Elementary/Secondary (0-12) Public Works Civil Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Irvin Poehlman Elizabeth Scott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21057 19a. Informant's Name/Relationship (Type, Print) 11630 Glen Arm Road Unit 18 Glen Arm, Maryland Ruth M. Poehlman (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 6-5-06 Baltimore, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland 21212 21. Signature of Funeral, Service Licensee rais 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) perative tractable post -0 welks Ran Adv anced Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? racture COVONAVY 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No 26. Place of Death | Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 FYes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending FALL 1 ☐ Yes 2 ☑ No investigation Noon M 2 Accident April 30,2006 3 ☐ Suicide

**Physician** /Medical Examiner Examiner

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Maryland 2121

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other traumatic event, the Mudical Examiner must be notified at

3

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical

27. Manner of Death 1 Natural

4 Homicide

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

parking Lot

Giant Grocery Store 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

28f. Location (Street and Number r Rural Route Number, Tally or Town State)

29b. Signature and title of certifier

29c. License number 1)25205

29d. Date signed (Month, Day, Year) June 1, 2006

30. Name and address of person who sompleted cause of death (Item 23a) (Type, Print) 8701 N. Charles GBMC

Balto, and

State Registrar

31. Date filed (Month, Day, Year) JUN 0 5 2006 32. Registrar's Signature

no

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 1 per do Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 6100 26 2006 Mabel 1 Pauls Mai /Medical and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner avida If Under 1 Year If Under 24 Hrs. 0 IMOVE Wn Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🕅 F Hours Director 213-01-1078 Maryland OCT 16. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28s-f ehov any injury or other traumatic event, the Madical Examinar must be notified at once. 1 ☐ Yes 2 X No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 6811 Campfield Road USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Baseball 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edgar Gibbons Jones Gertrude Graceman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 611 Central Ave., Room 301, Towson, MD 21204 Bridget Beres/Guardian of Person 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 5/31/06 Baltimore, MD 21. Signat (re of Funeral Servige Licensee 22. Name and Address of Facility Cremation Society of MD, Erward A Gregorchik 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Certification: To Be Completed by Physician/Medical Examiner Due to (of as a consequence of) Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. the attending physicien the documents of IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 Yes 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 / Inpatient 1 ☐ Yes 2 🗷 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA siut 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) osputal who completed cause of death (It 1 234) (Type, Name and address of person tRoad Randallstown Maryland

Registrar DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Year)

JUN 0 5

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2006

32. Registrar's Signature

	_	State Registrar	tate of Maryland		artment of Hotelin			Reg. No.	06	17548
Physicia	_	1. Decedent's Name (First, Middle, Last)	B: 11:0	V			2. Date of Dea	Day	Year	3. Time of Death
/Medic		4a. Facility Name (If not institution, give street	Hiddic		4b. City, Town, or	Location of Dea	May	28 4c. Cou	2006 nty of Death	0103 4
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Funeral Director		5. Social Security Number  2.12-18-4709  6. Sex 1 M  Usual Residence of Decedent	7. Age (In yrs. le		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		h y, Year)	9. Birthp Coun	lace (State or Foreign
land ow	-	10a. State 10b. County	10c. City	, Town or Lo	cation				1	0d. Inside City Limits
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ther de	Fune	The Market States	Armed Forces? 1 ☐ Yes 2 No		Was Decedent of His f Yes, specify Cubar		to Rican, etc.)	E	Black, White,	
O36	ρ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 □ No	Specify:		Spe	city: Bla	ch
21215-0036  within 72 hours after deeth with the Maryland gjene. et then "naturel", or Items 23a or 28e-f show et then "naturel", or Items 23a or 28e-f show in the Medical Examilmer in ust be notified at	Completed	15. Decedent's Educati (Specify only highest grade co	on mpleted)	16a. Deced (Give	dent's Usual Occupa kind of work done di DO NOT use retired)	tion uring most of wo	orking	16b. Kind o	Business/Inc	dustry
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Baltimo permit. Page Department of Important: If any Injury or		21. Signature of Funeral Service Licensee	<u></u>		Name and Address					inval Home
Balt permit. Departr Import any Inj once.		Lewy Ha	nis	52	40 Reist		on Bd		-	
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Box leath cert attendin	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			1	Date of delive Month	Day Year
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spitel ours a nersi i		29a. Certifier Certifying Physici	an: To the best of my knov	viedge death	occurred at the time	e date and plac	e and due to the	rause(s) and	manner as st	ated
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\		30. Name and address of person who comp  Babak Imanael, Da	leted cause of death (Item	23а) (Туре,	Heis ( fs 1	ted Chr	i la schon.	n c do -	MD	21152
Sta	te.	Babak Imanal, Do 31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	75,74	10.071	J 0- 217.11	9/4/		7
Registr		JUN 0 5 201	16 Herene	15 1	boote					

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Cer	tificate of	Death		, ,	Reg N	. 20	06 1754
Physicia	an/	Decedent's Name (First, Middl	e,Last)					2. Date of Month		y Year	3 Time of Death
ledical Exami	ner	Gary	Regan					May 2	29, 2006		1909 hrs
and to		4a Facility Name (if not institution  Johns Hopkins Bayvie	-		4	b. City, Town, or I Baltimpre	Location of De	eam		4c County of De	atn
Funeral		Social Security Number		e (In yrs. la	ast birthday)	If Under 1 Year	If Under 24	4Hrs 8. Date	of Birth (M		Birthplace (State or
Director		214 76 7649	1XM 2F	4	.7 Yrs.	Months Days	Hours	Min. Mar	ch 20	),1959 For	eign Country) Maryland
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w any		10a. State 10b. County			Town or Location	on					10d Inside City Limits
Maryland 28a-f show d at once.	ţ	Maryland Baltim	ore	Dung	dalk	10f Zip Code			100.0	Citizen of What Co	1 Yes 2 X No
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with the is 23a ce noti		11 Marital Status	12. Was Decedent	Ever in U S	S. 13. Was	Decedent of Hisp		( Specify Yes	or No-		erican Indran, Black,
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2121 ould be fill Mental F marked c event, t	Be	Anthony	Regan		100 10 7		Lo		Lee	Gayo	
O de Brisia	5	19a. Informant's Name/Relations Patricia Lee T		er)		Address (Street				yland 21	
무 걸 뚫 때 종		20a. Method of Disposition				tion (Name of cerr		Date		c Location - City	
Baltimore, permit Pages I an Department of He Important: If ite		1 X Burial 2 Cremation 4 Donation 5 Other Sp			rematory or oth cdens of		Cem. J	une 2,	2006 :	Baltimor	e County, Md
Baltimo permit Page Department Important: injury or ot		21 Cignature of the al Service				ame and Address		-			
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Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause								shock, or heart	Approximate Interval Between Onset and
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		Sequentially list conditions,	b	74401100 01	<i>y</i> •						
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	equence of	·):						
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of	·).						
executed an and al - trans		□ <b>V</b>	dit	~~#??a	27 porME	G,G856,6/12	)/06 TT				
	/Medical	X UNPENDED			· · · ·	1,0000,0/12	2/00 11			004 Data of dall.	
18760, rtificate be ing physic as the bur	an/N	23b. Was decedent pregnant in the past 12 months?	Live billin		2 Fet	al death 3	Ectopic pre	egnancy		23d Date of delive Month	Day Year
Box 68's death certifithe attending	Physiciar		4 Pregnant at	time of dea	ath 5 Oth	er (Specify)					
b.O. Be that the des	Phy	Part II. Other significant condit	9 Unknown	but not re	esulting in the ur	nderlying cause gi	iven in Part I	23e	Did tobacc	o use contribute	to the cause of death?
, P.O ires that to signed by	l by					, , ,		1	Yes 2	No 3 Pr	obably 4 🗸 Unknown
ords,	Completed								Was an		autopsy findings available o completion of cause of
Recol The law icate has	mp								autopsy performed Yes 2	? death?	`
tal Recian: The		25 Was case referred to medica				26.Place	of Death (Che		163 2	1 4	res 2 No
Vital hysician: this certif	o Be	examiner? 1 ✓ Yes 2 No	Hospital. 1 Inpatie	nt 2 🗸	ER/Outpatient	3 DOA	Other Nu	rsing Home	5 Resi	dence 6 Oth	er
Division of Vital Records, talor Attending Physician: The law requirers after death al Director: After this certificate has been sited in by the funeral director, page 2 should be	n: T	27. Manner of Death	28a. Date of Inju (Month, Day,Ye	ry ear)	28b. Time of In		y at Work?	28d Des	cribe how i	njury occurred	
Sior Attend death death sy the	catic	Pend	stigation	At he	form atom		es 2 No	206 1 000	tion (Ctores	t and blooming on a	De la New York
Divi	Certification:		d not be (Specify)	jury - At no	ome, rami, stree	t, factory, office bu	allaling, etc.		own, State)		Rural Route Number, City
Hospi 24 hou Funer tely fil	cal Ce	20a Cortifior	nysician: To the best of my	y knowledg	ge, death occurr	ed at the time, dat	te and place,	and due to the	e cause(s)	and manner as st	arted.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn.	Medica	one) 2 Medical Exa	miner: On the basis of exar and manner stated	mination ar	nd/or investigati			ed at the time,	date and p	olace, and due to	the cause(s)
	Ž	29b. Signature and title of certifie		/		29c License				Date signed (N	fonth, Day, Year)
		Theode ,	U Z	4-	11	O.C.N	/I.Е.		Ma	ay 30, 2006	
		30 Name and address of person Theodore King MD.	who completed cause of de Assistant Medical E	eath (Item	23a) r 111 Per	n Street, Bal	timpre MF	21201			
	tate		32 Registra			Groot, Dan		, 0 1			
Regis		31. Date filed (Month, Day, Year)	2006 Melicon	1 /	A DOM						

			For State Registrar		State of	f Maryla	-	artmen rtificat				lental Hy	giene Reg. No. 🤈	006	17550
	Physicia	an	1. Decedent's Nam									2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al			Ruby Sr.	mber)		4b. City.	Town, or	Location	of Death	Hay	3 / 4c, Cou	2006 unty of Death	15.20 PM
	Examin	er	01 1	ines ?	Hospital	,,,,,		6	alt	'mo-				N/A	
	Funeral		5. Social Security	umber	6. Sex 1 X M 2 ☐ F	7. Age (In yrs		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Feb 6,	th ay, Year)	Cour	lace (State or Foreign
	Director		215-10-9 Usual Residence of		ı₩ s□ ı		89 Yrs.					Feb 6	1917	Mary	land
	yland		10a. State	10b. County		10c. C	ity, Town or L	ocation						1	Od. Inside City Limits
	se Ma	ctol	Maryland		/A		Bal	timor							1X Yes 2 □ No
	with the or 2	Dir	3120 St		Street			10f. Zip		1229			10g. Citizen	of What Cour	itry?
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36	or its		1 ☐ Never Mari	_	ned 1 X Yes If Yes, Gi	2 □ No 1	941 945	1 Yes		Specify:		riican, otc.)	1	<sup>Black, White, Bo<i>ity: W</i>hi</sup>	
ő	within 72 hours after death with the Maryland ene. ene. than "natural", or iteme 23a or 28a-f show ta Medical Examinar must be notified at	Completed by	3 X Widowed		Year or E	Dates:	16a. Dece	dent's Usu	al Occupa	ation			16b. Kind o	of Business/Inc	
215	hin 72 3. In na	plet	(Spe	cify only highe	st grade completed) College (	1-4or 5+)	(Give	DO NOT u	rk done d se retired	du <i>ring</i> mos ()	st of work	ing			
213	filed wit Hygiene other the	Соп		<u>L</u>				Elect	cicia		- d - Name	. (Fina Adidda	1	ectric	al
Maryland 21215-0036	s 1 and 2 should be filed within 72 hc I Health and Mental Hygiene. Item 27 le marked other than "natur other traumatic event, tra Medical	To Be	17. Father's Name Willia		Lasi)							ie Smit		name)	
ary	should and Mer mark	F	19a. Informant's N	lame/Relations	hip (Type, Print)		19b. Mail	ing Address	(Street a	and Numbi	er or Rura	al Route Numb	er, City or To	wn, State, Zip	Code)
Σ	, g g E 5		JoAnn Co		aughter	201						alethor	*		
Jore	ages 1 nt of H : # ite			Cremation	3 □Removal from	State	Place of Disp cemetery, cre				06/0	Date		on - City or To	
Baltimore,	permit. Pages 1 Department of H Importent: if ite any njury or oti	1	4 ☐ Donation  21. Signature of F	uneral Service		rie	tro Cr		-		-				Maryland
ä	Dep Imp	j. 9	N 1/1/4	as Gre		-		301	Fred	rune leric	ral k Ro	ad Balt	ímore,	Maryl	and 21228
			shock, or hea	art failure. List	complications that only one cause on	caused the dec each line.	ath. Do not er	nter the mod	te of dyin	g, such as	cardiac	or respiratory a			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause disease or conditi- resulting in death)	on	a	Ciasts	w'c	Olec	rs						Imonth
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> 89	ntificating ph)		IF FEMALE:										-		
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Zoro	w requir been s should	eted		ypers	ension								Yes 2□N		ably 4 □Unknown
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S ital		Be Co	25. Was case refe	rred to medica	1			-		26. Place	e of Deatl	1 ☐ Yes ∩ Check only		1 🗌 Yes	2 X No
2 >	Physicien: r this certific ral director,		1 ☐ Yes 2 █			Inpatient 2						me 5□Resi			1)
		tlon:	27. Manner of Dea	5 Pendi	ng (Mor gation	of Injury oth, Day Year)	28b. Time Injury	M 2	28c. Injury Work	∤at k? Yes 2		28d. Describe	now injury oc	curred	
Division	l or Attend after death Director: A	Certification: To	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could	not be 28e. Place	e of Injury - At ling, etc. (Spec	home, farm, s					28f. Location ( City or To		ımber or Rura	I Route Number,
Ö	ital or irs afte rei Dir iled in		4 Tionnoide								***************************************				
	To the Hospital or At within 24 hours after of To the Funerei Direc completely filled in by	Medical	29a. Certifier (Check only one)	2 Medical	ng Physician: To the Examiner: On the band man	e best of my kr basis of examin nner stated.	nowledge, dea nation and/or i	th occurred nvestigation	at the tim	ne, date ar pinion, dea	nd place, ath occurr	and due to the red at the time,	date and pla	manner as store, and due to	ated. othe cause(s)
	To t To t	Σ	29b. Signature and	tille of centric	H.	0.		29	c. License	number 17	59	9	29d. Date sig	gned (Month, $31/200$	Day, Year)
_	6		30. Name and add	10 11	who completed cau allu, St.	se of death (Ite	em 23a) (Type Hospit	Print)	200.	Cato	u A	vy, Ba	(time	, MC	)-2/229.
ı	Sta Registr		31. Date filed (Mo.	nth, Day, Year	2006	Registrar's Sign	nature .	porte							the cause(s)  Day, Year)  O C.  1 2 1 2 2 9

State of Maryland / Department of Health and Mental Hygiene 16 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** June 3, 2006 3:00 P. M Mary Lou Ross /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Oeath 4c. County of Oeath Examiner Gilchrist Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (Sundry) | Months | Days | Hours | Min. (Month, Day, Year) | August 15,1920 | Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 □ M 2 💢 F Months 216-09-7597 85 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or items 23e or 28a-1 show any injury or other traumatic event, Ira Madical Examinar must be notitied at once. 1 ☐ Yes 2 No Baltimore Directo Maryland Towson 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 935 Ellendale Drive 21286 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Specify: White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Oecedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) V.P. Branch Administration Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Louis John Belzner Louisa Bonn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. Ross / Husband 935 Ellendale Drive Towson, Md. 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp. 6/5/06 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 York Road Mh Ruck Towson Funeral Home, Inc. Towson,Md. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Oeath Immediate Cause (Final disease or condition resulting in death) Physician Months /Medical Examiner Sequentially list conditions, if any, loading to ministrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a spineaquenea of): Examine led by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) spital or Attending Physician: The law requires that the tours after death.
neral Director: After this certificete has been signed by filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Oid tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 1 Yes 2 No 1□ Yes 2 XINO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Cospice 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Satural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funsral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D58303 3 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST BALTIMINE UD AMON CHAMIES, NO 6601 N. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 5 Registrar 2006

			1 - State of Maryland / Dep	eartment of Health and Mertificate of Death	lental Hygie	0000	17552
	Physic /Med		1. Decedent's Name (First, Middle, Last)  Gertrude Lillian Rus	sell	2. Date of Death	Day Year	3. Time of Death 4:45 P M
	/ Exami		4a. Fecility Name (If not institution, give street and number) Suburban Hospital	4b. City, Town, or Location of Death Bethesda		4c. County of Death	1
	Funeral Director		5. Social Security Number 6. Sex 113-03-0080 7. Age (In yrs. last birthday 88 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Ye October 26	9. Birthp Court 1917 New	lace (State or Foreign try) York
	ING Z1Z130036  be filed within 72 hours after death with the Maryland lal Hygiene. d other than "netural", or Iteme 23a or 28a-f show event, the Medical Examinar must be notified at	ector	10a. State10b. County10c. City, Town or LMarylandMontgomeryBethes			1	0d. Inside City Limits 1 ☐ Yes 2 🕅 No
	ler death with the M Iteme 23a or 28a-f	Funeral Director	10e. Street and Number 9806 Montauk Avenue	10f. Zip Code 20817	U	Citizen of What Coun	•
	5-0036 72 hours after de netural; or Item	þ	11. Marital Status  1 □ Never Married  2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spetif Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race · Americ Black, White, Specify: Whi	etc.
	Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryla th and Menial Hygiene. it? Ie marked other than "netural", or Iteme 23a or 28a-1 ehou traumatic event, the Medical Examinar must be notified at	Completed	(Specify only highest grade completed) (Given Elementary/Secondary (0-12) College (1-4or 5+)	odent's Usual Occupation a kind of work done during most of worki DO NOT use retired) Homemaker	ng	o. Kind of Business/Inc	dustry
-	Waryland 2121: 12 should be filed within hand Mental Hygiene. 19 marked other than "raumatic event, tha Mec	To Be Co	12 17. Father's Name (First, Middle, Last) Thomas Packer	18. Mother's Name	(First, Middle, Maid Strawbrid		
	b, Marylis end 2 should eeith and Mer m 27 le marks ner traumatic		Antoinette Benton / Niece 2 Her	ing Address (Street and Number or Rura			Code)
5 7	Baltimore, Mi permit. Pages 1 end 2 Depertment of Heelth a Important: If Item 27 is any Injury or other tra once.		4 Donation 5 Other (Specify) Montgomery	matory or other place)  Crematorium  June 2006	5, Be	Location - City or To	aryland
16.	Depending and Info		101303 /	2 Name and Address of Facility obert A. Pumphrey Funer 557 Wisconsin Avenue, E	ethesda, Ma	thesda-Chevy ryland 20814	-3501
90	Fnysician /Medical		23a. Pant 1. Inter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Arteriosclerotic Due to (or as a consequence of):	Cardiovascular Dis			Approximate Interval Between Onset and Death
e 6-2-	sate be executed thy sicien and the burial-transit	ical Examiner	Sequentially list conditions, it any, leading to infimediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  b.				
trud	death certific e attending p	by Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	y Day Year
Ger	wrequires thet the been signed by the should be detached	ed by PI	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause green in Part I.		o use contribute to the	
	The law ste has b	Completed			24a. Was an autopsy performed 1 ☐ Yes 2 ☑ 1	prior to com death?	sy findings available pletion of cause of
Russel	ng Phys Ifter this	Certification; To Be	25. Was case referred to medical examiner?  1   Yes   2   No	28c. Injury at 2 Work? M 1 Yes 2 No	te 5 ☐ Residence 8d. Describe how in  8f. Location (Street	and Number or Rural	
Ĉ	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu		29a. Certifier  (Check only one)  1 Certifying Physicien: To the best of my knowledge, death control on the basis of examination and/or income.	occurred at the time, date and place, a	City or Town, Sta	(6) and manual	
•	To the by within 24 To the Complete	Medical	29b. Signature and Hille of certifier  Detroite MD	29c. License number 034174		Pate signed (Month, D	
1	Q		31 Date filed (Month Day Year) 32 Pegistrar's Signature	rgetown Road, Beth	esda, Mar	yland 2081	.4
	Sta Registr	-	5. Date lines (World U.W. 1935) 2006 See See See See See See See See See Se	rede			

DHMH 17 Rev 1/2001

Jack Randolph Shanahan

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 17553

		l - For State Registrar				Cen	tificate	of I	Death				Re	g. No.	.00	0 1	100
Physicia	_	Decedent's Name	(First, Middle	e,Last)								2	Date of Deatl Month		ear ear	3. Time of D	
ledical Exami	ner	Jack R.	Shana	han									May 30, 20	006		1752 h	rs
		4a. Facility Name (if 1538 E. Clen			et and num	ber)		4b	Baltimo						ty of Death		
Funeral Director		5. Social Security Nu 217-40-6		6. Sex	2 F	. Age (In yrs. la 64		Yrs.	If Under Months	1 Year Days	If Under	Min.	8. Date of Birt 3/24/	· · · · · · · · · · · · · · · · · · ·	YY) 9. Birl Foreig Co		e or
_	- [	Usual Residence of I				140 00	T									10d. Inside	City Limits
vlaryland 28a-f show any 1 at once.	٥	10a. State 1	0b. County	N	I/A	Toc City,	Town or Lo	callo		timo	ore (	City				1 X Yes	
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Num 1538 E.		nt St	reet				10f. Zip C		230		10	g. Citizen of \	What Cour	ntry?	
with ms 23; be not	era	11. Marital Status			Was Dece Armed For	dent Ever in U.S			Decedent s, specify (				cify Yes or No-		ice - Ameri hite, etc.	can Indian, E	3lack,
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	by Funeral	Never Married Widowed	4 Div	orced if Yes	Yes s, Give Year ates:	2XX No	1		Yes 2	X No	specify.			Specify	y:	whi	ite ———
hours "natur		15. Decedent's Edu Elementary/Secon			ghest grade College (1-		16a. Dece durin		s Usual Oo st of workir					16b. Kind of	Business/i	naustry	
1036 vithin 72 ene er than "	mpleted	12			4	401 3+)		Re	estau							staura	int
21215-0036 uld be filed within 72 Mental Hygiene marked other than 'e event, the Medical	Be Co	17. Father's Name (F Bernard									E	Eliza	First, Middle, Nabeth Ha	amp			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygieine Important: If item 27 is marked other than injury or other traumatic event, the Medical	υ	19a Informant's Nan Linda M					15	38	E. C.	leme	ent S	Stree	ral Route Num et, Bal	timore	MD 2	1230	
nore, lages I and mt of Heal nt: If item other tra	1	20a. Method of Disposition 1 Burial 2	X Cremation	1 3 R	temoval fro	m State Bayy	Place of Dis crematory of View						Date 2, 2006	20c. Location Balt:			
Baltimore, permit. Pages I ar Department of He. Important: If ite		Donation 5 21 Signature of Fun															
Physician		23a. Part I. Enter the	e disease, or	complication	ons that ca	used the death	Do not en	ter the	e mode of	dying, s	uch as ca	AVEI	respiratory arre	est, shock, or	heart	Approxima	ate Interval
/Medical Examiner	8 8	failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a Intraoral Gunshot Wound  Due to (or as a consequence of):														Onset and eath	
		Due to (or as a consequence of):  Sequentially list conditions,  b.														ļ <u>.</u>	
	Examiner	if any, leading to importance. Enter Under (Disease or injury the	mediate lying Cause	C		consequence of											
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ng ng as t		IF FEMALE: 23b. Was decedent p past 12 months?			Live bi	utcome of pregr rth ant at time of de	2	1	al death	3	Ectopic	pregnan	су	23d Date Month	of delivery	) Day	Year
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, P.O. Box 6 tres that the death cer signed by the attendi	ğ	Part II. Other signif	icant condit	tions con	tributing to	death but not re	esulting in	the ur	nderlying c	ause gr	ven in Pa	irt I.		bacco use co			
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on of ouding Phath		27 Manner of Death 1 Natural	5 Pen	- 1	FOUND: May 30,	Day, Year)	FOUND 1735 hrs	r;	jury 20	_	es 2 🗸	S	Subject sho		unea		
Division of Vital Records, pital or Attending Physician: The law requir ours after death erral birector: After this certificate has been si filled in by the funeral director, page 2 should t	Certification:	2 Accident 3 Suicide 4 Homicide	6 Cou	ld not be ermined	28e. Place	of Injury - At ho	ome, farm,		t, factory, d	office bu	ııldıng, et	- 1	28f. Location (\$ or Town, S 538 E. Cle	tate)			
the Hospit in 24 hour the Funer pletcly fil	Medical Ce	29a Certifier 1		aminer: On	To the best	of my knowled f examination a	ge, death o										
To the within To the comple	Med	29b. Signature and	title of certifi		manner st	ated			29c.	License	number			29d Date s	igned (Mo	nth, Day, Yea	3 <i>r</i> )
			9 N	N.	1/6					O.C.N	M.E.			May 31,	2006		
10		30. Name and addre				e of death (Item al Examine)		Pen	n Street	, Balti	more,	MD 212	201			11:20 (0.00)	ALLES
	tate		h Day Xear	2006	32 Je	gistrar's Signati	8 1	be	asi o								
Regis	$\mathbf{H}$		A11 A 6		1	Carried and	- 4		-								

ORIGINAL

			1 - For Registrar	State of M		Department of Certificate		and Menta	Hygier Reg. 1	- Z U U b	17554
			1. Decedent's Name (First, Middle, La	ast)					of Death		3. Time of Death
	Physici /Medio		Julia An	n Smit	h			Mon 5		Day Year	5120 am
X.	Examin		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, To	wn, or Location of	of Death		4c. County of Dea	
			Franklin Square	2 HUSpital	enter		sedale			Baltino	re
	Funeral		5. Social Security Number 6.	Sex 7. Ag	ge (In yrs. last birt	Months   [	Year If Under: Days Hours	Min. 8. Date /Mor	of Birth th, Day, Yea	9. Bi	thplace (State or Foreign ountry)
	Director		235 36 9173 Usual Residence of Decedent	1□ M 2∏ F	79	Yrs.		Dec.	22,1	926 Arı	sta, West Va
3	M m		10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
	f sho	ŏ	Marriand Daltimon		Essex	,					1 ☐ Yes 2√☐ No
4	288	Directo	Maryland Baltimor 10e. Street and Number	<u>e</u>	LSSe/	10f. Zip Co	ode		10g.	Citizen of What C	
1	3a o	0	107 Essex Avenue			21:	221			U	SA
	ms 2	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Deceder If Yes, specify	nt of Hispanic Orig	gin? (Specify Yes	or No-	14. Race - Am	
9	or he	F	1X Never Married 2 Married	1 Yes 2 X		1 Tes, specify		i, Pueno nican, e	ic.)	Black, Wh	
3	rai'.	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	\$45 m.c.c.	12163 20	атто эрвену.			Specify:	White
5	nati	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)	16a.	Decedent's Usual C (Give kind of work of	done durina most	t of working	16b.	Kind of Business	/Industry
<b>y</b>	De.	ם	Elementary/Secondary (0-12)	College (1-4or	5+)	'life. DO NOT úse : Homemake:	*			Own Home	
7	be fleed within 2 mous after beam with the Maryland tall Hygiene. Ad other than "natural", or items 23a or 28a-1 show event, the Madical Exeminar most be motified at	ပိ	17. Father's Name (First, Middle, Las	t)		nonenake.		or's Name (First, A			
0	Aental rked o tic eve	To Be	Alexander Smi				1	ella	Lepe		
~ .	and 2 should Balth and Mer n 27 is marke ier traumatic		19a. Informant's Name/Relationship Donna Zeauskas	(Type, Print) (niece)		Mailing Address (5					
υ,	tem tem other		20a. Method of Disposition		20b. Place of	Disposition (Name	of	Date	20c.	Location - City or	Town, State
2	nages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 (			y, crematory or othe w Cremato		6/3/2006	Bal	Ltimore,	Maryland
	permit. Fages I and a should be filed within 7.2 hours after bearn with the marylan permit. Fages I and a should be filed to the filed to the fage of the filed fi		21. Sgrature of Aurieral Service Lice		1	22. Name and A	Address of Facilit	y Bruzdzi	nski	Funeral	Home PA
			23a. Pat 1. Enter the disease, ocor	nplication that cause	d the death. Do n					x Maryla	nd 21221 Approximate
			shock, or heart failure. List only	one care on each li	ine.	ot enter the mode c	or dying, such as	cardiac or respira	tory arrest,		Interval Between
	hysician /Medical		disease or condition resulting in death)		ointest		id				& weeks
	xaminer			Due to (or as	a consequence of	of):	eroerr				
		P.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of	arcmon	29				
. 3	nosit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
,	be executed ician and purial-transit	Exa	resulting in death) Last	c Due to (or as	a consequence of	of):					
	are be executed hysician and the burial-transit	ical	(	d							
0	g phy as th										
5	attending physical of for use as the t	<u>N</u>	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2  Fetal death	3 □Ectopic preg	2222			23d. Date of de	livery
	ne att	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a 9☐ Unknown		5 ☐ Other (speci				Month	Day Year
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'n	peugi pe de	by	Part II. Other significant conditions	contributing to death b	out not resulting in	the underlying caus	se given in Part I.	23e			o the cause of death?
5	been si should	ted	<del></del>						1 Pes	2 □ No 3 □ P	robably 4 Unknown
נו נו	has bo	Completed						24a	Was an autopsy	prior to	utopsy findings available completion of cause of
	Autorialing Filts strain. The sector. After this certificate haby the funeral director, page	ő						10	performed? Yes 2.⊠1	death?	2 □ No
וומ	ertific actor,	Be	25. Was case referred to medical examiner?	-				of Death  Check	only one)		
	this o	P.	1 Yes 2 No	Hospital:						6 □Other (Spe	ocify)
	After	io io	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		ijury	Injury at Work?		cribe how in	jury occurred	
מו	tor: /	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not I	00		М	1 Yes 2 N				
	of the control of the	Certification;	4 Homicide determined	28e. Place of in	jury - At home, fai ic. <i>(Specify)</i>	m, street, factory, o	ffice		tion (Street or Town, Sta		ural Route Number,
	ours a	2	29a. Certifier 1 Certifying P	hysician: To the best	of my knowledge	death occurred at 1	the time, date and	d place, and due	o the cause	(s) and manage a	n state of
2	To the propriet of without by the training repairs that the taw requires that the beautified to the training tra	ledicai	(Check only 2 Medical Exa	miner: On the basis o and manner st	of examination and	Vor investigation, in	my opinion, deat	th occurred at the	time, date a	ind place, and du	e to the cause(s)
4	withir To th	Me	29b. Signature and title of certifier	17-4-6	hing We	29c. L	icense number		29d. D	Date signed (Mon	h, Day, Year)
) (				1	- 7 WU	7. BF	SOOD	000	5/	3/106	
	5		30. Name and address of person who	completed cause of o	death (Item 23a) (	Type, Print)				11 -	
	~		Dr. Tzunchine	1 Wu 90	00 Frank	1. Post Type, Print) Liv Squa	re Driv	e Balt	more	Md 21	237
	Sta		31. Date filed (Month, Day, Year)	32. Redistr	rar's Signature	porte			,		
	Registr	ar	JUN 0 5	ZUU0	was so	Par marin					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth Month Day Year **Physician** Dorothy May Stottlemyer June 2006 2:52 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
May 24,1923 Social Security Number Hospital Center Itimore guare If Undar 1 Year 9. Birthplace (State or Foreign Country) West Virginia Age (In yrs. lest birthdey) **Funeral** Months Days 215 24 2809 1□M 200 F 83 Director Usual Residence of Decedent should be filed within 72 hours efter death with the Merylend nd Mental Hygiane. marked other than "natural; or ttems 23a or 28e-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director Maryland Baltimore Essex 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 110 N. Staurt Street 21221 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Black. White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify. Be Completed by Widowed 4 ☐ Divorced White Year or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Custodian Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d 2 should be fit in end Mental H Charles Oscar Writt Viola Taylor Alexander 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) grand permit. Pages 1 and 2.
Department of Health elimportant: If Itam 27 is any Injury or other trait Kimberlie A. Jackson 110 N. Stuart Street Essex Maryland 21221
ce of Disposition (Name of Date 20c. Location - City or Town, State daughter) Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, cremetory or other place) 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 6/5/06 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Inc 22. Name and Address of Facility 21. ature of Funeral Service License Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 Einer the disease, or complications that can sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only the cause on such line. Approximate Interval Between Onset and Death art Physician Immediate Cause (Final disease or condition resulting in death) /Medical oronari Examiner Due to (or a consequence of): Physician/Medical Examiner or Attanding Physician: The law requires thet tha death certificeta be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): To the Hospital or Attanding Physician: The law requires thet the der within 24 hours effect death.

To the Funeral Director: After this certificate has been signed by the ecompletely filled in by the tuneral director, page 2 should be deteched to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 🗆 Yes 2 No 3 Probably 4 Unknown O.P.D Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Dementia 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 3D DOA 2 ER/Outpatient 28c. Injury et Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Yeer) 29b. Signeture and title of certifier 29c. License number 6/3/06 MA 30. Neme and address of person who completed cause of death (ttem 23e) (Type, Print) Franklin Square Drive, Baltimore MD, 21237 Wassim 9000 Hitti 32. Begistrar's Signature 31. Date filed (Month, Day, Yeer)

DHMH 16 Rev 6/95

Registrar

JUN 0 5 2006

Doroth

Stottlemyer

441-	Salva and	•	For State Registrar	State of Mar	rylan				ealth a		-	giene Reg. No.	006	)	17556	
18.	Physicia	9	Decedent's Name (First, Middle, Lass     Classelle		~~ <b>+</b> ~						2. Date of De Month	ath Day	Year	r	3. Time of Death $Q: 20 \rho_{M}$	
	/Medic	al	Blaze Charle  4a. Facility Name (If not institution, give	<u> </u>		)	45 Cin	Tour	Lagation	of Donath	June	03	County of De		1:20PM	_
	Examin	er	-	ALTH CAKE.			4b. City	0	Location of		_	40.	County of De	am		
	Funeral	-	5. Social Security Number 6. So	ex 7. Age	(In yrs. I	ast birthday)	If Unde	r 1 Year	If Under	24 Hrs.	8. Date of Bir	th	9. B	inhplac	ce (State or Foreign	-
	Director		219 18 4427	EM 2□F	81	Yrs.	Months	Days	Hours	Min.	Feborin 5	<sup>1</sup> /1/92/5			and	
	pur A		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	ocation							10d	I. Inside City Limits	_
	Maryis	tor	Maryland Baltimor		-	Essex									1 ☐ Yes Z ☐ No	
	h with the	al Director	10e. Street and Number 1714 Oakfield Ave	enue			10f. Z	<sup>P</sup> 2122	1			10g. Citia	en of What O	Country	1?	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or itema 23a or 28a-f show or other traumatic event, the Marical Examinar must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:		s. 13.	Was Deci		ispanic Ori n, Mexicar Specify:		pecify Yes or No Rican, etc.)		4. Race - An Black, Wh Specify:		2.	
5-0	72 hc	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)		16a. Dece (Give	kind of w	ork done d	lurina mos	t of worl	king	16b. Kir	nd of Busines	s/Indus	stry	
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/lan	should be and Mental I marked of	m	Salvatore P Spinna	ato					As	sunda	a Catalo	di				
, Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than any injury or other traumatic event, Item Mangone.	1	19a. Informant's Name/Relationship (7 Michael Spinnato -								atonsvi.					
Baltimore,	Pages 1 and of He int: If item		20a. Method of Disposition  1  Burial	Removal from State	20b. P	lace of Disponentery, creation	osition (Na matory or	ame of other plac	e)		Date 2006		ation - City o			
Ħ	artme ortant injury		4 □ Donation 5 □ Other (Specify 21. Sign#ture/of Funeral Service-Licen	^	рау				s of Facilit		-					-
ä	permit. Departnimports any inju		Mohn W. Bur	Knusko-		1	407	old E	aster		uzdzins venue R				ne PA Land 21221	1
			23a Parti. Enter the disease, or compared shock, or heart failure. List only	olications that caused the	he death	n. Do not en							CIC II	A	pproximate Iterval Between	
	Physician		Immediate Cause (Final disease or condition	Phene		va'								0	Imeens.	
	/Medical Examiner		resulting in death)	Due to (or as a	consequ	uence of):	. 1	-L.							2 weeks	
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13.	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a	consequ	uence of):								-		_
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7. F.	The law requires that the death certificate be executed ase has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal	death 3	⊒Ectopic j ⊒ Other (s					2	3d. Date of d Month	elivery Da	ay Year	
18 CA irds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions of Alfheimes	ontributing to death but dewentia	not resu	ulting in the u	underlying	cause give	en in Part I				se contribute ]No 3□1		cause of death?	Ì
SflNNATo, 18	The law require has been sage 2 should	Completed	0								24a. Was auto perfo	psy ormed2-	prior to death?	autopsy comp	y findings available letion of cause of	
√∨A Vital	ilcian: Th certificete rector, pag	BeC	25. Was case referred to medical examiner?						26. Place	of Dea	th Check only	M-1-1-		,5 2(		
of V	Physician: this certifice	2	1 Yes 2 No	Hospital: 1 Impatient		ER/Outpatie			4 🗆 140	rsing H	ome 5 🗌 Resi	dence 6	Other (Sp	ecity)		
Spono	ding P. h. After t funera	tlon:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year)	28b. Time o Injury	of M	28c. Injun Work	rat ⟨? Yes 2□	No	28d. Describe	how injury	occurred			
S	ii or Attending Physicien: The after death.  Director: After this certificete hid in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined		y - At ho (Specify	ome, farm, st	reet, facto	ry, office			28f. Location ( City or To	Street and wn, State)	Number or I	Rural R	Route Number,	_
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical C	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	ysician: To the had of niner: On the basis of e and manner state	examinat	wledga, deal tion and/or in	th annuire rvestigatio	s at the lim n, in my op	na date an pinion, dea	id stage th occur	and due to the rred at the time,	date and	and manner place, and di	as state ue to th	e cause(s)	-
VA 5000000	within Toth compi	Me	29b. Signature and title of certifier				29	c. License	number			29d. Date	signed (Moi	nth, Da	y, Year)	
	11		Main. 1	1.D.				P-	1861	3.		丁~	ne,03	3,2	006.	
-	10.4		30. Name and address of person who	completed cause of dea	ath (Item		1	Qar	100	. ka	1500 0	116		7.90	-21219	
			31 Date filed (Mooth Day Year)	32. Registrar	's Mona		Man.	701	12- (	NON	mie Isa	WIIM	ove 1	VLI)	- 41219	1
-46	Sta Registra		31. Date filed (Month, Day, Year)	2006	July 1	B.	dos	de la								

/Medi	ian	Decedent's Name (First, Middle, Last	51)	6 6/06/88	JH		2. Date of Deat Month	Day Ye	
Examir	cal	Charles Ear  4a. Fecility Name (If not institution, give <b>Baltimore Washin</b> Maryland Primary	street and number)	al Ctr	4b. City, Jown, o	r Location of Death Burnie	June	2 200 4c. County of E Anne A	Death
Funeral Director		5. Social Security Number 6. Se		(In yrs. last birthday) 58 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 6	Year) 9.	Birthplace (State or For Country) ennsylvania
28e-f show	Director	10a. State 10b. County  Maryland Anne An  10e. Street and Number	rundel	10c. City, Town or Lo	mbrills			0-00	10d. Inside City Lin 1 Yes 2 🔀
3e or		2490 Red Fall Cour	rt.		10f. Zip Code	21054		Og. Citizen of What United S	-
jiane. r than "naturel", or Items 23e or 28e-f show the Medical Exertinet must be rictified at	by Funeral	11. Marital Status  1 Never Married Married  3 Widowed 4 Divorced	12. Was Oecedent E Amed Forces? 117 Yes 2 N If Yes, Give Year or Dates:			lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - A Black, V	vhite
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ad other	To Be Co	17. Father's Name (First, Middle, Last)  Ewing Sutton	<u> </u>	sen	lor Syste	ms Analyst  18. Mother's Name <b>Jesse</b> <del>Colleen</del>	(First, Middle K	Maiden Surname)	Government
s m		19a. Informant's Name/Relationship (T)  Colleen Sutton/v				and Number or Rura	l Route Number	City or Town, Stat	
ient of Health int: If item 27 i		20a. Method of Disposition  1 XBurial 2 Cremation 3 1  4 Donation 5 Other (Specify,	Removal from State	20b. Place of Dispo	osition (Name of matory or other plac	o) June	ate 6,	20c. Location - City Smithfiel	or Town, State
Department of P Importent: If ite any injury or ot once.		21. Signature of Funeral Service Licens		01/07 DC	2. Name and Addre		uneral	Home	
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yeer **Physician** 9:30 A<sup>M</sup> Eileen S. Sobkowich June 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8020 Keeton Rd Elkridge Howard If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2 F 049 20 3380 77 March 4,1929 Pennsylvania Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "naturei", or items 23a or 28a-f show dical Examiner must be notified at 1 Tyes 2 TXNo Director MD Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8020 Keeton Road 21075 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 ₩idowed 4 Divorced Year or Dates: White ar then "nature". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 .. Pages 1 and 2 should be filed w tment of Health and Mental Hygier tant: If item 27 is marked other th jury or othar traumatic event, the Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert Deignan ٩ Anna Kellet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert J. Howarth/Son 9657 Corn Tassel Ct. Columbia, MD 21046 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Pag Department Important: I any injury o \* 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory 6-3-2006 Catonsville, MD 22. Name and Address of Facility Harry H. Witzke's Family FH, INC 21. Signature of Funeral Service Licensee M01044 len 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Em PhysemA **Physician** YEAR.S resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 XNo been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has l irector, page 2 s autopsy performed? 2X No 2 No 1 🗌 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home St Residence 6 Other (Specify) 2 1 ☐ Yes 21X No 1 Inpatient ġ 2 ER/Outpatient 3 DOA Director: After this in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicide To the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) William HOWERS! MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William FLOWERS, MI) 32. Registrar's Signature 31. Date filed (Month, Day, Year)
JUN 0 5 2006

DHMH 17 Rev 1/2001

State Registrar

06-03785

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene Chester James Schade

ester James .		1- For State	r iviaryland / Depa <i>Cer</i>	rtment of tificate of		ental Hygi		No		
Physicia	aņ/	Registrar 1. Decedent's Name (First, Middle,Last)					Date of Death	No -		3) Time of Death
edical Exami	ner,	CHESTER JAMES SCHADE		1		J	une 3, 200	6		0205 hrs
		4a. Facility Name (if not institution, give s Howard County General Hos		48	o. City, Town, or Locati Columbia	ion of Death		4c. Count	y of Death d	
Funeral		Social Security Number 6 Sex	7. Age (In yrs. la	ast birthday)		Jnder 24Hrs. 8	. Date of Birth		(Y) 9. Birtl	hplace (State or
Director		189.62.1350 <sup>1</sup> XX <sup>M</sup>	1 2 F 37	Yrs.	Months Days H	ours Min.	AUGUST 8	1968	Foreign Cou	n Intry) <b>PA</b>
		Usual Residence of Decedent					AUGUST 0	, 1900		
w any		10a. State 10b. County	10c. City,	Town or Locatio	n					10d. Inside City Limits
Maryland 28a-f show d at once.	ģ	MD HOWARD  10e. Street and Number	co	LUMBIA	10f. Zip Code		1404	. Citizen of V	Mark Cause	1 Yes 2 No
ne Mar or 282 fied at	Director	Toe. Street and Number			Toi. Zip Code		100	. Citizen of v	VIIat Couri	uyr
with the is 23a e noti	ral	6312 SADDLE DR. 11. Marital Status	2. Was Decedent Ever in U.	S 13. Was	21045-560 Decedent of Hispanic		y Yes or No-	14. Ra	USA ce - Americ	can Indian, Black,
or item	Funeral	1 Never Married 2 Married	Armed Forces?  Yes 2 XX No	If Ye	s, specify Cuban, Mexi	ican, Puerto Ric	an, etc.)	Wh	ite, etc.	
after a	by F		Yes, Give Year r Dates.		res 2 <b>XX</b> No spe			Specify	MUI	
hours natur Exam	ed	15. Decedent's Education (Specify only			s Usual Occupation (G st of working life, DO N			6b Kind of B	Business/Ir	ndustry
36 hin 72 e than than trical	plet	Elementary/Secondary (0-12)	College (1-4 or 5+)	DI ANT MA	NACED			LIONIEWIE		nn.
215-0036 be filed within 72 hours aftental Hygiene rked other than "natural" ent, the Medical Examine	Completed	17. Father's Name (First, Middle, Last)		PLANT MA		ther's Name (Fi		HONEYWE		<u> </u>
21215 ould be file Mental H marked o	å	JAMES R. SCHADE		_	M/	ARION TRU	XAL			
→ 8 5 2 4 1	입	19a Informant's Name/Relationship (Type	e, Print )	19b. Mailing	Address (Street and	Number or Rura	I Route Numb	er, City or To	wn, State,	Zip Code)
- 말등 등 등 [		JAMES R. SCHADE  20a. Method of Disposition	206.		DROP RD. N. on (Name of cemetery			20c. Location	n - City or T	Town, State
		1 XX Burial 2 Cremation 3XX	Removal from State	crematory or other						
Baltimo permit Page Department ( Important:		4 Donation 5 Other Security 21 og tu of Funeral Service Licen		IN UNION	me and Address of Fa	6.7.2	2006	-	IRWIN,	PA
Ba perm Depr		K. GREGORY FINK	M01148	FIN	CRAIN HWY SW	E. P.A.	NIF MD	21061		
Physician		23a. art I. Enter the disease, of complications. List on the cause in each	ations that caused the death.						eart	Approximate Interval Between Onset and
/Medical Examiner	2 1	Immediate Cause (Final disease a.	Cardiac arrhythm	a due to	interstitial	fibrosis	and car	diomega	ly	Death
			ie to (or as a consequence o	F):						
	ē		ue to (or as a consequence o	·):						
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated	ie to (or as a consequence o							
uted id ansit	Ä	events resulting in death) Last d	to to (or up a compoducinos o	7-						
760, cate be executed physician and the burial - transit	Medical	X UNPENDED	AMENDED item#23a,	27, perME,	g857,7/13/06	TT				
760 icate b physic the bu	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg					23d Date		
Box 687 death certific the attending p	cian	past 12 months?	1 Live birth 4 Pregnant at time of de	ath	I death 3Ect er (Specify)	topic pregnancy		Month	Da	ay Year
Boy death the attr	Physician/	1 Yes 2 No 9 Unknown	9 Unknown	0 0	(Opcony)					
P.O. Box 687: sthat the death certification by the attending e detached for use as t	by P	Part II. Other significant conditions	ontributing to death but not re	sulting in the un	derlying cause given i	n Part I.				he cause of death?
S, P.C puires that in signed l			· · · · · · · · · · · · · · · · · · ·					2 No :		ably 4 Unknown
ords, aw requir nas been s 2 should	plet						24a. Was an autopsy perform	·		opsy findings available ompletion of cause of
Records, The law require freate has been si	Completed						1 🗸 Yes 2		1 Yes	2 No
Division of Vital Records, P.O. Box 68760, no the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after the death for the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.	å	25 Was case referred to medical examiner?	spital. 1 Inpatient 2	EP/Outpationt	Othor	eath (Check only  Nursing H		esidence 6	Other	
Division of Vital tal or Attending Physician: rs after death al Director: After this certiled in by the funeral director	. 70	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of Inj			d. Describe ho		Other:	
on cending ath he fun	tion	1 X Natural 5 Pending	(Month, Day, Year)		1 Yes 2	2 No				
visior or Attend fter death birector: in by the	ifica	2 Accident Investigation 3 Suicide 6 Could not be	28e Place of Injury - At he	ome, farm, street	factory, office building	g, etc. 28f			ber or Rur	al Route Number, City
Divi	Certification:	4 Homicide determined	(Specify)				or Town, Sta	te)		
Division  To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	cal		<ul> <li>To the best of my knowledgen the basis of examination a</li> </ul>							
To th within To th	Medical	29b. Signature and title of certifier	nd manner stated	nd/or investigatio	29c License num					th, Day Year)
	2	Zab. Signature and title or certifici	18		O.C.M.E.	ide!		June 3, 2		rr, Day, rear)
Rock		30 Name and address of person who con	moleted cause of death (Item	23a)						
600			ant Medical Examiner		Street, Baltimore	e, MD 21201	1			
	tate	31. Date filed (Month, Day Year) 5 2	32. Regisfrar's Signatu	ire	. w .					
Regis	trar	2011 0 3 7	UUU SERAN	St. fg	944)					
DUBALL 47 Day 47	001									

DHMH 17 Rev 1/2001 OCME 2006

ORIGIÑAL

			1 - For State Registrar	State of Marylar		rtment of I			ene 006	17560
	Physici /Medio		1. Decedent's Name (First, Middle, Last)  CALVIN	SHREW	SiBui	RY		2. Date of Death Month	Day Year 31 2004	3. Time of Death 5:00 AM
	Examir Funeral		- / - / L/  J/ L	street and number)  OMBARD  7. Age (In yrs.			LTIMU If Under 24 Hrs Hours Min	th  S. Date of Birth  (Month, Day, Y	4c. County of Death  BALTE  9. Birth ear)  County of Death	MONE City pplace (State or Foreign
	Director	or	Usual Residence of Decedent  10a, State  10b. County	10c. Ci	ty, Town or Loc	ation		1110	-1930 West	10d. Inside City Limits
	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23e or 28e-f ehow event, Ite McJical Evertinar must be notified at	rai Director	Maryland Bartin 10e. Street and Number 3424 East Lor	mbard St.	Dal	10f. Zip Code 212	-24	10g	. Citizen of What Cou	
900	iours after de iral', or items L'Examinar m	d by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates: Koyea	If	/as Decedent of I Yes, specify Cub ☐ Yes 2 No	Hispanic Origin? (§ an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify: WI	, etc.
21215-(	od within 72 h gjene. er than "natu , Itte Medice	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation	16a. Decede (Give k life. D	ent's Usual Occup ind of work done O NOT use retire	during most of wo d)	rking 161	Shipya	
aryland	should be file nd Mental Hy marked oth umatic event	To Be (	17. Father's Name (First, Middle, Last)  Cellie  19a. Informant's Name/Relationship (Type	Shrewsburg		Address (Street	M	me (First, Middle, Mai	Bryant	in Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23s or 28s-f show styl injury or other traumatic event, the Macical Examination and page.		Norma Redden / S  20a. Method of Disposition  1 Burial 2 Cremation 3 Red  4 Monation 5 Other (Specify)	20b. I	3424	East Low	bard St.	Baltimore Date 200 31,2006 H	MD 21 c. Location - City or T	224 own, State
Baltir	permit. P Departme Importan eny injur		21. Signature of Funeral Service License	ee	22. 75 1	Name and Addre	ss of Facility And	tomy Gifts Re Suite P. Ha	gistry nover, MD	
Lage	Physician /Medical Examiner	Examiner	23a. Par1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to (or as a consec	NECK	the mode of dyir		c or respiratory arrest,		Approximate Interval Between Onset and Death
Box 68760,	eath certificate be executed attending physician and for use as the burial-transit	dical	230. Was decedent program	Due to (or as a consequence of pregnant of Diese of Dies	ancy	ctopic pregnancy			23d. Date of deliv	,
0.	that the deaned by the at	Physician/Me	in the past 12 months?  1  Yes 2 No 9 Unknown  Part II. Other significant conditions cont	4 □ Pregnant at time of d 9 □ Unknown	eath 5 🗆 (	Other (specify)		23a Did tobaco	Month co use contribute to t	Day Year
Records,	v requires been sign should be	Completed by							2 □No 3 □ Prol	pably 4 Dunknown
Vital Re	ician: The lav certificate has rector, page 2:	Be Comp	25. Was case referred to medical				26. Place of Dea	autopsy performed 1 Yes 24	? death?	opsy findings available impletion of cause of
ŏ	ling Phys	Certification: To E	27 Manner of Death 1 Natural 5 Pending 2 Accident Investigation	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injur	er: 4 🗆 Nursing H	1	e 6 □Other (Specin	<b>(y</b> )
Divis	0 4 9 7		3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	y) 			City or Town, Si		
	To the Hospital within 24 hours a To the Funeral I completely filled	Medicai	one) 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	tion and/or inve	stigation, in my o	pinion, death occu	rred at the time, date	and place, and due to	the cause(s)
)	7. } F.≧ E. 8		29b. Signature and title of certifier			29c. License	563		Date signed (Month,	
1	XX			DEPOTAL BACK	-Timar	n in the second	ANALY 8	M.Ks	Gibson	MD
	Sta Registr		31. Date filed (Month, Day, Year)	3). Registrar's Signa	ture Losa	e,				

			1_ For	State of Ma					/lental Hy	giene	006	17561
			Ragistrar  1. Decedent's Name (First, Middle, Last,			Certific	ate of L	)eath	-	Reg. No.	000	17001
	Physici	an	7 WAS 87						2. Date of De Month	Day	Yeer	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	orge Augus	st Smit		ity Town or	Location of Death	June		006 ounty of Death	4:09 A M
	Examili	lei		Maris						40. 00		
	Funeral		Social Security Number 6. Sec.	7. Age	(In yrs. last birt		nder 1 Year	imonium If Under 24 Hrs.	8. Date of Bir (Month, Da	th	Balti 9. Birth	place (State or Foreign
2	Director		218-10-2331 1 <sup>10</sup>	M 2□F	89	Yrs. Mont	hs Days	Hours Min.	September		Cou	aryland
42	pue *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location			1			
2	/aryli	ō			· · · · · · · · · · · · · · · · · · ·	. or coodion	_					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
0	ith the Marylan or 28a-f ehow	Director	Maryland Baltin  10e. Street and Number	nore		10f	Zip Code	Lmonium	Т	10a Citizar	n of What Cou	
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7	hours after death with the Maryland tural', or Iteme 23s or 28s-1 ehow at Examinar must be notified at	Funerai		12. Was Decedent Ev		13. Was De	ecedent of His	spanic Origin? (Sp	ecify Yes or No		Race - Ameri	
(a) 9	after dea or Iteme	Fu.	1 X Never Married 2 ☐ Married	Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give			specify Cubar s 2∭ No	, Mexican, Puèrio Specify:	Rican, etc.)		Black, White,	etc.
5-0036	72 hours "natural",	d by	3 Widowed 4 Divorced	Year or Dates:	WWII	10.10	5 211140	эрөспу.		Sp	ecify:	White
1 TO	"nati	Completed	15. Decedent's Edu (Specify only highest grade	cation co <i>mpleted)</i>	16a.	Decedent's U (Give kind of	work done di	uring most of work	ing	16b. Kind	of Business/In	idustry
2121	within ene.	mc	Elementary/Secondary (0-12)	College (1-4or 5+	)	III. DO NO	Tuse retired)					
d 2	e filed within at Hygiene. I other than '	o C	17. Father's Name (First, Middle, Last)	4			Own	er 18. Mother's Name	e (First, Middle,	Maiden Su	Advert	ising
$\frac{2}{2}$	ild be lental ked c	To Be	Anthon	y August S	Smith							- 1
ary	shor and N		19a. Informant's Name/Relationship (Ty	-		Mailing Addr	ess (Street at	nd Number or Run	Mary El a <i>l R</i> oute Numbe			
0/ ≥ ≥	s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygiene. Item 27 Ie marked other then "natural", or Iteme 23e or 28e-1 ehov other traumatic event, I'm Medical Examinar must be notified at		Michael Anthony St	mith/ Neph	ew 378	2 Plum	n Meado	w Drive	Ellicot	t City	, Mary	land 21042
) C	permit. Pages 1 and Department of Health Important: If Item 23 any Injury or other t		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R		20b. Place of cemetery	Disposition (	Name of		Date		ion - City or To	
3.5	Pag ment ant: ury c	4	4 □ Donation 5 □ Other (Specify)	dinoval from State	Monte	comery torium	n Inc.	Jur 7,		Beth	esda.	Maryland
Jun Baltimor	ermit Depart Dep		21. Signature of Funeral Service License	90		22. Name Bethe	and Address	of Facility Rob	ert A.	Pumphi	cev Fun	peral Home/
	403 e d		Jen Jest		00335	Bethe	sda, M	aryland.	20814-3	561	WISCOI	sin Avenue
			23a. Part1. Enter the disease of complishock, or heart failure. List only or	e cause on each line	ne death. Do n	ot enter the n	node of dying	, such as cardiac o	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		fmmediate Cause (Finaf disease or condition resulting in death)	Con	gest	100	He	eart	Fac	lux	e	OHSON WIND DOWN
	Examiner			Due to (or as a	<del>c</del> ónsequence o	if):						
, =		Jer	Sequentially list conditions. If any, leading to immediate	Due to (or as a	consequence o	t);						
V	cuted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
်ဝွ	e exe		resulting in death) Last	Due to (or as a	consequence o	f):						
8760,	icate be executed physician and s the burial-transit	edical										
			IF FEMALE:	20.16								
Box B	eath certil attending for use a	Physician/M	in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir	Fetal death		pregnancy			23d.	Date of delive Month	ery Day Year
Do	t the de by tha lached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	ne or death	5 🗌 Other	(ѕреспу)					,
0		by Pr	Part II. Other significant conditions con	tributing to death but	not resulting in	the underlyin	g cause giver	in Part I.	23e. Did to	bacco use	contribute to th	ne cause of death?
(S-C)	quires n sign uld be	leted b							1 🗆 Y	es 2 🗆 N	o 3 Prob	pabiy 4 Unknown
Jh 8	aw requir is been si 2 should	piet							24a. Was a	an   24	4b. Were autor	nsv findings available
. B	The lay	Comple							autop. perfor	meg!	death?	psy findings available mpletion of cause of
ital	sician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?		7.7			26. Place of Death		2 X No	1 🗌 Yes	2 LI No
たさ	d is	2	1 ☐ Yes 2 No	ospital: 1  Inpatient		patient 3	DOA Other	4 ☐ Nursing Hor	ne 5 ☐ Resid	ence 6 X	Other (Specify	Hospice
, / n	ding Pt h. After th funeral		27. Manner of Death 1 (A)Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	/ear) 28b. Ti	me of jury	28c. Injury a Work?	at 2	28d. Describe h			
Sic	Attending r death.	cat	2 Accident investigation 3 Suicide 6 Could not be			М		es 2 🗆 No				
1 A =	aftar death aftar death Director: d in by the f	Certification:	4 ☐ Homicide determined	28e. Pface of Injury building, etc.	r - At home, fare (Specify)	n, street, fact	ory, office	2	281. Location (S City or Tow	treet and Nu n, State)	umber or Rura	l Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled in	a C	29a. Certifier 1 Certifying Phys	ician: To the best of r	my knowledge	death occurr	ed at the time	date and place	and due to the o	ausale) and	manner	ated
	24 h	edicai	(Check only 2 Medical Examin	er: On the basis of ex and manner state	xamination and	or investigati	on, in my opir	nion, death occurre	ed at the time, o	late and plac	manner as sta ce, and due to	the cause(s)
	To the To the comp	Me	29b. Signature and attle of certifier			2	29c. License	number	Ż	9d. Date sig	gned (Month, L	Day, Year)
	1.1		1.				1)4	3725		6/	1/2	006
	30x1	1	30. Name and address of person who con	npleted cause of dear	th (Item 23a) (T	ype, Print)	230	DIL O	lane	1 Va	lleu	RD
	2		Tarig /11a	hmood	MD		Tin	Du Du	m;	MI	Ja	1092
	Stat Registra		31. Date filed (Month, Day, Year) JUN 0 5 201	32. Rigistrar's	Signature	house		- 75	,			

State of Maryland / Department of Health and Mental Hygiene 1. Decedent's Name (First, Middle, Last) 2. Date of Death County of De 3. Time of Death Month **Physician** DO A M STICHMAN ILLIAN MULL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (12/22/1908 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕅 F 97 213-01-7460 MD Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits or items 23a or 28a-f shov item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Mudical Examplar must be notified at Directo MD BALTIMORE OWINGS MILLS 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4730 ATRIUM COURT #546 21117 USA Funeral filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No WHITE Specify: δ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OFFICE MANAGER J.SCHOENEMANN & COMPANY 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill ment of Health and Mental H tant: If Item 27 is marked off jury or other traumatte even Be 18. Mother's Name (First, Middle, Maiden Surname) RITTERMAN NATHAN SARAH SHAPIRO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MELVIN ROTTMAN / FRIEND & POA 8 JOANNA COURT - PIKESVILLE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If eny injury or once. SHAAREI ZION CEMETERY 05/30/2006 ROSEDALE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician ENO STAGE RENAL FAILURE /Medical resulting in death) Due to (or as a consequence of): Examiner ASCVD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine as the burial-transit The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physicien Completed by Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 5 Other (specify) 4 Pregnant at time of death be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Director: After this certificate has been s in by the funeral director, page 2 should 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 X No 1 ☐ Yes 2 X No 1 Tes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural Injury death. t ☐ Yes 2 ☐ No 2 Accident investigation after death 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours af the Funeral Di letely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Fune completely f (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mehla m.o D41410 30. Name and addr of person who completed cause of death (Item 23a) (Type, Print) 10 GINDER P MEHTA RENTER
32. Registrar's Single LANDRUSTPHIN MO HOS PATAL

DHMH 17 Rev 1/2001

Registrar

			1 - For Stata Registrar	· PState of Ma			irtment of F tificate of i		Mental H	ygien Reg. N		16	17563
€.	Dhyeisi		1. Decedent's Name (First, Middle, L						2. Date of D			ar	3. Time of Death
	Physici /Medic		Eric Thow	IPSON					Jun			006	02:35AM
)	Examir	er	4a. Facility Name (If not institution, g		1 11	,	4b. City, Town, o	0.1		4	c. County of (	Death	
				any land Med Sex 7. Age		ter	If Under 1 Year	If Under 24 H			n/a		
	Funeral Director			100	e (In yrs. last birt) 31	riday) Yrs.	Months Days	Hours M	in. (Month, L	ay, Year	9.	Birthpl Count	ace (State or Foreign
			212-13-3275 Usual Residence of Decedent		)				11/01	/19/	4 [1]	ary.	land
	how		10a. State 10b. County		10c. City, Town	or Lo	cation				-	10	d. fnside City Limits
	Sa-f.	Director	PA York		New	par	k						1☐Yes 2☐No
	or 28	Dire	10e. Street and Number				10f. Zip Code			10g. C	itizen of Wha	t Count	ry?
	ath v		166 Hopewell Roa				173				nited		
	item item	Funerai	11. Marital Status 1 XNever Married 2 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🖫		13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or herto Rican, etc.)	10-	14. Race - A Black, V		
38	urs af	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	10	1	☐ Yes 2⊠ No	Specify:			Specify: W	hite	9
ğ	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show he Medical Examiner must be notified at	Completed	15. Decedent's	Education	16a.	Deced	ent's Usual Occup	ation		16b. I	Kind of Busin	ess/Ind	ustry
215	thin 7 e. en "r	pie	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5	+)	life. [	kind of work done of NOT use retired	during most of w d)	vorking				,
7	filed wil Hygien other th	Con	10	n/a		Con	struction	n		Ge	neral	Cons	struction
Maryland 21215-0036	be fill d off	Be	17. Father's Name (First, Middle, Las					18. Mother's N	lame (First, Midd	e, Maide	n Sumame)		
<u>=</u>	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Ma	은	Calvin Paul Thom						on R. Sm				
Z Z	ges 1 and 2 should be filed within 72 hours after death with the Marylar it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be institled as		19a. Informant's Name/Relationship				g Address (Street				or Town, Sta	te, Zip (	Code)
<b>6</b>	1 an Heal tem 2		Sharon R. Neutze 20a. Method of Disposition	1 (Mother)	20b. Place of	6 H Dispos	opewell 1 sition (Name of patory or other place	Road, Ne	ewpark, I	PA	17352 -ocation - City	or Toy	yn State
ē	ages ent of ht: If i		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		cemetery	y, crem	crematory or other place	(a)	/05/2006	·	altimo		
altimore,	permit. Pages 1 and 2 Depertment of Health a important: If item 27 ti eny injury or othar tra ance.	. 1	21. Signature of Funeral Service Liq		Dayv		Name and Address	_					
ä	P S E S		MAN C	K/			107 Wilke		Hubbard I				
y	Ten S		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused by one cause on each lin	the death. Do n	ot ente	er the mode of dyin	g, such as card	iac or respiratory	arrest,		1 1	Approximate Interval Between
P.	Physician		Immediate Cause (Final disease or condition	Myo	chirdial	I	Marchi	n		1/			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	a consequence o	of):	0	,	16	EXAMINE	R	+	1 day
	Cxammer	_	Sequentially list conditions,	b. Coll	une I	nto	XICation		A / Non	EXAM	<u> </u>		2 days
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7	al-tran	Examiner	that initiated events resulting in death) Last	cDue to (or as a	a consequence o	of);		Jan 65	ARO.				
68760,	tificate be executed g physicien and es the burial-transit			d				CERTIFICATION					
9	tificat ig phy es th	ledicai		-									
ŏ	The law requires that the death certi tte has been signed by the attending tage 2 should be detached for use e	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth		3□	Ectopic pregnancy				23d. Date of	deliver	y
0	b dea	sici	in the past 12 months?	4□Pregnant at 9□Unknown			Other (specify)				Month		Day Year
۵.	res that the dei igned by the a be detached f	Phy	9 Unknown										
Vital Records,	signe d be d	b	Part II. Other significent conditions	contributing to death bu	it not resulting in	the un	derlying cause give	en in Part I.	1		_		cause of death?
Ö	w require been signature	etec									!□No 3□		
Rec	has ge 2	Completed							24a. Wa auto	s an opsy iomed?	24b. Were prior deat	to com	sy findings available pletion of cause of
œ	ificate or, pa	မ Co	25. Was case referred to medical						1 ☐ Yes	2 Z N		Yes 2	.□ No
>	Physician: The la r this certificate has ral director, page 2	0 8	examiner?	Hospital:	nt 2 ER/Out	nationt	3 DOA Othe	or	eath <i>Check only</i> Home 5 Res	197	5 CO# //	261	
Division of	g Ph ter thi	n: T	27. Manner of Death	28a. Date of fnjur (Month, Day	у 28b. Т	ime of	28c. Injury Work		28d. Describe	how inju	ry occurred		A /
Ö	l or Attending Ph efter death. Director: After th I in by the funeral	Certification:	1 Natural 5 Pending	on June 1 20	006 22	ijury 1200		Yes 2 No	Myocard		yavena e inti		
Š	r Att	tific	3 ☐ Suicide 6 🗖 Could not 4 ☐ Homicide determine		ry - At home, far . (Specify)	m, stre	et, factory, office		28f. Location City or To	(Street at	nd Number o	Rural	Route Number,
	urs ef		- <del>-</del> -			OME	-		HANCH	-	reet.	Bal	to MD
	To the Hospitel or Attending Physician: within 24 hours effer death. To the Funeral Director: After this certifica cumpletely filled in by the funeral director.	edicai	29a. Certifier 1 Certifying F (Check only one)	Physicien: To the best of	examination and	death Vor inv	occurred at the time estigation, in my of	ne, date and pla pinion, death oc	ce, and due to the curred at the time	cause(s , date an	and manne d place, and	r as star due to t	ted. he cause(s)
	o the	Med	29b. Signature and title of certifier	and manner sta	180.		29c. License				ite signed (M		
	F ≥ F Ø		Leffany	Bridges NI	. D			19669	5				
•	1		30. Name and address of person wh	/		Type F		1 4 4 -		JU	m 3,	U	06
	)		Tiffan M. Brides	M.D.	22	Ch	the Gree	ME ST	out:	Post	2/2 /	10	242.24
	Sta	. 39	31. Date filed (Month, Day, Year)	ACP	r's Signature	1		- V I		1		V	- 101
1	Registr	ar	JUN 0 5 2	UUb Albert	US.	ST.	Mei						

				State of Maryland / Department of Health and 1- State Amend Item 26 oer verb., G856, 06/05/2064 Death		0000	1 1
	8		اي	1. Decedent's Name (First, Middle, Last)	2. Date of Dea		3. Time of Death
		Physic /Medi		Lillian Tyler	May	18, 2000	0 440 am
•	7	Examir	ner	4a. Facility Name (If not institution, give street and number)  Ab. City, Town, or Location of Deat  By Firm VC	1 y Les	4c. County of De	1
		Funeral		5. Social Sebuty Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9 Ri	thplace (State or Foreign
	F	Director		2/3-38-/695 1□M 2□F C4 Yrs. Months Days Hours Min.	8/8/1	941	MD
		yland		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
		ith the Marylan or 28a-f show	ctor	MD NA Baltimore			1 ☑Yes 2 No
		with th	Dire	10e. Street and Number 10f. Zip Code	1	log. Citizen of What C	ountry?
		leath w	by Funeral Director	2529 McCulloh St 21217  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	Specify Ves or No-	14. Race - Am	> A
	9	after dea or Itema	Fun	Armed Forces? If Yes, specify Cuban, Mexican, Puen  1 ■ Never Married 2 Married 1 Yes 2 ■ No	to Rican, etc.)	Black, Wh	
()	5-0036	72 hours natural;	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify:		Specify: P	lack
9	15-	within 72 hours after death with the Maryland ene. then "natural", or Itema 23a or 28a-f show i.a Medical Expirate much be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  [Give kind of work done during most of wo. life. DO NOT use retired)	rking	16b. Kind of Busines:	/Industry
13	212	filed within Hygiene. Ither then	mo	Elementary/Secondary (0-12)  12-14  College (1-4or 5+)  12-15  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)		Red CR	555
	nd	s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygiene. Item 27 is marked other then "natural", or itema 23a or 28a-f ahou other traumatic event, the Medical Expresser must be notified at	Be		me (First, Middle, I	Maiden Sumame)	
E	Marylan	2 should be and Mental is marked o	은		Wilson		
3	<b>∑</b>	and 2 s lealth an m 27 is i			0.0	City or Town, State,	
1	ore,			20a. Method of Disposition 20b. Place of Disposition (Name of		20c. Location - City o	Town, State
1	Baltimore	ment of tent: If it		I ba build 2 Cremation 3 Chemioval num State	2/2006	Baltimer	MD.
	Ball	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licensee	Funeral 8	SVC	
				23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	Ke; Balt	more, MD	Approximate
	1	Physician		shock, or heart failt <del>ord</del> . List only one cause on each line.  Immediate Cause (Final disease or condition  MUD Ca f d a line of the condition of the cause of th	L	651,	Interval Between Onset and Death
		/Medical Examiner		resulting in death)  Due to (or at a consequence of):	WVI		-
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		uted d ansit	Examiner	riany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
	o,	an and rial-tra		resulting in death) Last  Due to (or as a consequence of):			1
2	8760	cate be executed physician and the burial-transit	dical	. Endstage renal dis	lase		
10	9	eath certific attending p for use as	/Mec	IF FEMALE: 23b. Was decedent organist 23c. If yes, outcome of pregnancy			
100	. Box	es that the death ceri igned by the attendin be detached for use	by Physician/Me	In the past 12 months?  1		23d. Date of de Month	ivery Day Year
0	P.0	at the de	hys	9 Unknown			
X	ds,	Attending Physician: The taw requires that the death certific death. rdeath. rctor: Atter this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	l by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		pacco use contribute to	
	COL	w requir been s	Completed		1 Ye		obably 4 Dunknown
	Re	The tav	omp		24a. Was ar autops perform	y prior to ned? death?	topsy findings available completion of cause of
	/ital	iclan: Th certificate rector, pag	BeC	25. Was case referred to medical examiner? 26. Place of Dea	1 ☐ Yes 2 ath Check only on		2 No
	of \	ding Physician: The n. A. After this certificate ha funeral director, page	မ	1 → Yes 2 No Hospital: 1 □ Inpatient 2 ▼ ER/Outpatient 3 □ DOA Cther: 4 □ Nursing H		ence 6 Other (Spe	cify)
	O	ding F th. After funera	tlon	27. Manner of Death  1 A tural 5 Pending 28a. Date of Injury 28b. Time of Injury Work? 2 Accident Investigation  28a. Date of Injury 28b. Time of Injury Work?  1 Yes 2 No	28d. Describe ho	w injury occurred	
	Division of Vital Records,	Attendi	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Str	reet and Number or R	ıral Route Number,
	ā	urs after rral Dir		Dunanty, etc. (appeary)	City or Town		
		To the Hospitel or Attant within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge 3 ath sound at the time date and place (Check only one) 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the ea	tucs(c) and manner at ate and place, and du	stated. to the cause(s)
_		Mithin To the	Me	29b. Signature and title of certifier 29c. License number	29	9d. Date signed (Mont	h. Day, Year)
				mg/kll D18327	/	nay 19	2006
	(	(His		30. Name and address of period who completed cause of death (Item 23a) (Type, Print)  Moges gebrenaram 4660 W: [Ken	1	1 01	2000
	*	Sta	te	31. Date filed (Month, Day, Tear) 32. Registrar's Signature	us Ho	e Bult	416
		Registr		JUN 0 5 2006			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 2006 10:36 AM UNE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death RALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Numberunk Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Days Hours Months 1 ☐ M 2 🖸 F 54 Sep 30, 1951 Maryland Usual Residence of Decedent 10b. County 10c, City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2√2 No Maryland | Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3323 Ryerson Circle 21227 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Deli Clerk Retail Food 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Austin S. Gordon Sadie M. Karn 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew C. Windsor / Husband 712 Birch Avenue, Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Y Burn 2 ☐ Cremation 3 ☐ Removal from State ☐ Donalion 5 ☐ Other (Specify) Mark's Cemetery 6/7/06 Petersville, Maryland 21. Sign ture of Funeral Service Licente 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 | Fetel death in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 X to 2 X 10 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date If Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

/Medical Examiner P.O. Box 68760, × Division of Vital Records,

use as the burial-transit to the Hospital or Attending Physician: The law requires that the death certificate be executed and the attending physicien and for use as the buria should be detached page 2 certificate within 24 hours effer death.

To the Funeral Director: Affer this certific completely filled in by the funeral director, 1-

**Physician** /Medical

Examiner

Funeral

Director

or 28a-f show

Items 23a

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natural

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "na any injury or other traumatic event, tra Medic once.

**Physician** 

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

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Completed

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Examiner

Physician/Medicai

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Medical Certification; To Be

4 Homicide

29a. Certifier

29b. Signature a

State Registrar

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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

of death (Item 23a) (Type, Print), Hanover St. Balt. Ma

31. Date filed (Month, Day, Year)

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		-	For State Registrar	State of Maryland		tment of H			giene 2	006	17566
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WINDSOR, ANNA

			For State Registrar	State of Ma	-	Departme <i>Certifica</i>		lealth and N Death		Reg. No. 2	106	17568
	Discovini.		1. Decedent's Name (First, Middle,	Last)					2. Date of D Month	eath Day	Year	3. Time of Death
	Physicia /Medic	_	David			Whitfield	<u>d</u>		05-	26-	06	9:54 am
	Examin		4a. Facility Name (If not institution,	give street and number)		4b. Cit	y, Town, o	r Location of Death		and the second	y of Death	
			Franklin Square	Hospital C.	enter	B	0500		· · · · · · · · · · · · · · · · · · ·	Ba	Him	
	Funeral		5. Social Security Number 6	5. Sex 7. Age 1X  M 2  F	e (In yrs. last bin		er 1 Year s Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	irth Pay, Year) 22-1950	9. Birthp	place (State or Foreign ntry)
	Director		218–54–0875	24	56	115.			01-2	22-1950		Md.
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	n or Location					1	Od. Inside City Limits
	larylan show	5		N A	Bal	timore						1 XYes 2 No
	Ne M	Director	10e. Street and Number				Zip Code			10g. Citizen of	What Cour	ntov2
	with t	ă	1117 Tace Dri	ve Apt. A	_1	101. 2	212	21		US		id y :
	s after death with the Maryland , or Items 23a or 28a-f show kaminer must be notified at	Funeral				12 Wes De-			nositu Vos os N	L	ce - Americ	can Indian
	er de	une	11. Marital Status	12. Was Decedent I Armed Forces?		If Yes, sp	pecify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Bla	ck, White,	
36	s aft	by F	1 X Never Married 2 Marrie 3 Widowed 4 Divorced	d 1 ☐ Yes 2 ☑ N II Yes, Give Year or Dates:	10	1 ☐ Yes	2 <b>X</b> No	Specify:		Speci	fy:	Black
8	within 72 hours after ene than "natural", or Ite ne mad call Examina		15. Decedent's		16a	Decedent's Us	sual Occup	pation		16b. Kind of E	Business/In	dustry
<u>₹</u>	"nai	Completed	(Specify only highest	grade completed)		(Give kind of v	vork done	during most of work d)	king	TOD. TUITO OF E	) doi:100@111	destry
12	withi ene. then	Ę.	Elementary/Secondary (0-12)	College (1-4or 5	i+)	Assem		Worker		Leve	r Bro	others
Da v.d	Hygie Hygie ther	Ö	12th grade 17. Father's Name (First, Middle, La	ast)				18. Mother's Nam	e (First, Middle	<u> </u>		Je.1025
a A	od De Co	Be	Sollie	,	Mhi	tfield		Anni	0	Гоо		Armstrons
<u></u>	should ind Men i marke umatic	2	19a. Informant's Name/Relationshi	in (Type Print)			ss (Street	and Number or Rui		Lee	State Zir	Armstrong
Na S	h an 7 ts r		Rosalie Rhodes		Friend	1117		e Drive				
ું. • _•	1 and Healt		20a. Method of Disposition		20b. Place of	Disposition (N	lame of		Date	20c. Location		
10	in the first of the second of		ty□ Burial 2 □ Cremation			ry, crematory of ing Me			-06			wn, Md.
二二	tmen tent jury		4 Donation 5 Dother (Spe		1	,						
[Uh; +field], $DavdBaltimore, Maryland 21215-0036$	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Importent: If Item 27 is marked other than any Injury or other treumatic event, the Magnee.		21. Signature of Funeral Service Li	tee tee	7			H. East	Baltin 1101	nore, Md E. Nor	. 212 cth A	202 .ve.
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that caused	the death. So	not enter the m	ode of dyir	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	0 1		Benal	di 601	asa				Onset and Death  20 4ears
	/Medical		resulting in death)		a consequence		1130	<u>use</u>				20 genis
	Examiner			b. EXSCH	naui na	tion	lue.	to AV G	raft f	ailure	,	2 hours
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Division of Vital Records, P.O. Box 68	Physician: The law requires that the death certifica t this certificate has been signed by the attending ph ral director. page 2 should be detached for use as th	by PI	Part II. Other significant condition	ns contributing to death b	ut not resulting i	n the underlying	g cause giv	ventin Part I.	23e. Did	tobacco use cor	ntribute to t	he cause of death?
,ds	w requires to been signer should be	D D							1	Yes 2 1 No	3 ☐ Prot	oably 4 Unknown
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<u></u>	icate								1 Yes		1 🗆 Yes	2 □ No
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<u>s</u>	death death tor: the	icat	2 Accident investigation 3 Suicide 6 Could no	ot be 290 Place of Ini	-			7.00 2	28f. Location	. , , ,	_	al Pauta Number
ĭŽ	or Al	Certification:	4 Homicide determin	28e. Place of Inj building, et	c (Specify)	OVNE	ory, office		City or 1	own, State)	#1	Q ESSEX, MD
۵	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director. page	caiCe	29a. Certifier 1 Certifying	Physician: To the best examinar: On the basis o	of my knowledge	e, death occurre	ed at the ti	me, date and place	, and due to the	e cause(s) and n	nanner as s	tated.
	the H in 24 the F iplete	Medical	one)	and manner st								
	To To E	2	29b. Signature and title of certifier	10.0	•40			se number		29d. Date sign		
			ontm+	TON,	MD		noc	161662	-	05/	26/2	006
	Ĭſ		30. Name and address of person v	who completed cause of o	death (Item 23a)	(Type, Print)		061662 are Driv	/	/-	, /	
_	7		Dr. Jonathan	Hansen 9	1000 Fr	anklin	29 uc	are Driv.	e Dali	h more,	Md 2	1231
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUN 0 5	· 2006 32. Registr	ar's Signature		0					

DHMH 17 Rev 1/2001

ORIGINAL

Jashington, William E. Please Type or Print in Black Indelible Ink **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ E. Washington William 0036 hrs Medical Examine May 28, 2006 4a. Facility Name (if not institution, give street and number) 4b City, Town, or Location of Death 4c County of Death NA John Hopkins Hospital Baltimore If Under 1 Year If Under 24Hrs. B. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or 5. Social Security Number Age (In yrs. last birthday) 6 Sex Funeral Months Days Hours Director 01 - 31 - 1974Country) 32 216-02-0201 1 X M 2 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits any 1 X Yes 2 28a-f show Reisterstown Baltimore Md. Director 10f Zip Code 10e. Street and Number 10g Citizen of What Country ě 21136 USA 45 Foxrun Ct. items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? White, etc. 1 X Never Married 2 Married Yes 2 X No f Yes, Give Yea Divorced 1 Yes 2 X No specify Black Widowed Specify "natural" þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical other than Baltimore, MD 21215-0036 ges I and 2 should be filed within 7 of Health and Mental Hygiene. Forklift Operator Hart Industries 12th grade 17 Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) event, Be Washington Rita Washington Gilbert 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Cashell Ct., Perry Hall, Latasha Grant Friend Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State permit Pages | Department of H Important: If it crematory or other place) Burial 2 Cremation 3 Removal from State  $^{1}X$ onation 5 Other Specify Cem 6-6-06 Dundalk Carmel ō 22 Name and Address of Facility ature of Funeral Service icens 21202 Baltimore, Md. 1101 E. North Ave. March F.H. East Approximate Interval rt I. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** Between Onset and lure. List only one cause on each line. /Medical Death Excited delirium diate Cause (Final disease Examiner ndition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transi Physician/Medical X AMENDED item#20c,23a,27,28a-f,perFH,ME,g856,6/20/06 TT X UNPENDED attending physician or use as the burial To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death
within 24 hours a Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the buriar Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 🗸 Yes 2 No 25 Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other 4 Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 DOA 1 V Yes No 2Ba. Date of Injury (Month, Day, Year 28c. Injury at Work? 2Bd. Describe how injury occurred Manner of Death 2Bb. Time of Injury Certification: Natural 1 Yes 2 X No 5 Pending excited delirium in police custody Fnd 5/28/2006 Fnd midnight 2 Accident Investigation 2Bf. Location (Street and Number or Rural Route Number, City Baltimore, 1822 Fleet Street 28e. Place of Injury - At home, farm, street, factory, office building, etc X Could not be 3 Suicide determined (Specify) found in bar Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 28, 2006

State

Registrar

DHMH 17 Rev 1/2001 OCMF 2006

5 200

Ripple MD.

30. Name and a

Mary G

31. Date filed (Month

ORIGINAL

111 Penn Street, Baltimore, MD 21201

empleted cause of death (Item 23a)

rar's Signature

Deputy Chief Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** MARIE HUTCHISON WALTER JUNE 2006 12:00 P.M /Medical 4c. County of Deeth 4b. City. Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner PARKVILLE BALTIMORE OAK CREST NURSING CENTER if Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Funeral 1 □ M 2 □ xF Days Hours Yrs. Director 7/30/1923 MARYLAND 215-14-3088
Usuet Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "naturel", or items 23s or 28s-1 show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 21 No Director BALTIMORE PARKVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number APT. 4120 21234 USA Funeral 8820 WALTHER BLVD. 14. Race - Americen Indian, Black, White, etc. 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Vo Yes 2 □ No frYes, Give Year or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE ۾ 3 □ Widowed 4 □ Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 4 YEARS REGISTERED NURSE HEALTH CARE 17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Be DINA ASCHE HOMER MILLER HUTCHISON 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9325 OAK WHITE ROAD Department of Heelth Important: if Itam 27 BALTIMORE, MD 21236 HOLTON HUTCHISON/BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State METRO CREMATORY, INC. 6/3/06 CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD P. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Chrome Obstructive Pulmany Disease Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Examine ettending physicien end for use es the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? perteusion 1 No 2 No 3 Probably 4 Unknown 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed 1 Y95 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 27. Menner of Deeth 5 Pending 1 Naturel 1 🗌 Yes daath. investigetion 2 Accident 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours of To the Funeral Di completaly filled in edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated 2 Medical Examiner: On the besis of exemination and/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) and menner stated. (Check only one) 29d. Date signed (Month, Day, Yeer) 29b. Signature end Ale of certifier 60. Name end address of person who completed cause of death (Item 23a) (Type, Print) 8800 31. Dete filed (Month, Dey, Year)

32. Registrar's Signature

ORIGINAL

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**DHMH 16 Rev 6/95** 

State

Registrar

H. WALTER OG/OI GODE

			State of Maryland / D  1 - State of Maryland / D  Registrar Amend Item #8 Per FH G856 6	ера	ırtment d	of Health a		tal Hyg		006	17571
	Physici	an	1. Decedent's Name (First, Middle, Last)  Malinda K. Wilson	,	7 00 012			ate of Death fonth	n Day 26	2006	3. Time of Death 11:20A M
	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City. Toy	wn, or Location o		У	7	ounty of Death	11.20A
	Examin	er	Anne Arundel Medical Center			apolis				ne Arı	undel
x.	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bird 219-64-9323 1 M XX 50		If Under 1 Y Months D	ear If Under 2 ays Hours	Min. Apr	ate of Birth Manual Day,	9 19	9. Birtho Coul 55 Mai	place (State or Foreign ntry) ryland
	pue		Usual Residence of Decedent  10a, State 10b, County 10c, City, Town	or Lo	cation					1	10d. Inside City Limits
	Maryla f eho	ōl	Maryland Anne Arundel Annap								XX es 2 □ No
	28a-	rect	10e. Street and Number		10f. Zip Co	ede		10	Og. Citizer	n of What Cour	ntry?
	h with	a D	1804 Bowman Dr.		214	401			U	SA	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 ie marked other then "natural", or Itema 23a or 28a-f ehow important: if Item 27 ie marked other then "natural", or Itema 23a or 28a-f ehow pring rights of the fraumatic event, the Medical Examinar must be natified at ance.	by Funeral Director	11. Marital Status  XXNever Married 2□ Married 3□Widowed 4□Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1□Yes 2▼No If Yes, Give Year or Dates:		Vas Decedent f Yes, specify ☐ Yes 🎾☐	t of Hispanic Orig Cuban, Mexican KNo Specify:	gin? (Specify , Puerto Rica	Yes or No- n, etc.)		Race - Americ Black, White, pecify: B1	etc.
21215-0036	within 72 ho ane. then "natur is Medical	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. L		occupation tone during most etired) ative A			A. A	of Business/fn Co. on Age	Community
Maryland 2	ould be filed within Mental Hygiene. Parked other then patic event, The M	To Be Co	12th 7yrs  17. Father's Name (First, Middle, Last)  James E. Smith				r's Name (Fir.			mame)	2
lan	2 should and Men ie marke aumatic				-	treet and Numbe			•		
	1 and 1ealth em 27 ther tr		Artina Trader(Daughter) 59  20a. Method of Disposition 20b. Place of			ia Ave	Green			A Ib.	125
Baltimore,	Pages nent of h int: if its ury or o		Cerneter	y, cren	natory or other	hurch 6					e, Md.
Balt	permit. Pages 1 and 2 Department of Health s important: if item 27 is eny injury or other tra <u>pnce.</u>		21. Signature of Funeral Service Licensee  Jarry 4. Rass MOOY83	8	21 Wes	ddress of Facility Sese & S st St.	Annar	olis	. Md		01
5			23a. Part1. Enter the disease, or complications that caused the death. Do r shock, or heart failure. List only one cause on each line.	not ente	er the mode of	f dying, such as	cardiac or res	piratory arre	est,	- resident	Approximate Interval Between Onset and Death
1 20	Physician		Immediate Cause (Final disease or condition resulting in death)	181							1409
	/Medical Examiner		Due to (orcas a consequence of	of):							,
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	of):							
	ocuted nd transit	amir	Cause (Disease or injury that initiated events c	_							
760,	te be executed ysician and ie burial-transit	cal Examiner	Date to for as a consequence of	or):							
687	ficate p phys		d								
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregn Other (specif				230	I. Date of delive Month	ery Day Year
	quires that an signed b uld be deta	6	Part ff. Other significant conditions contributing to death but not resulting in	the ur	nderlying caus	se given in Part I.		23e. Did tob			he cause of death? pably 4 □Unknown
I Records,	The law reate has bee	Completed						24a. Was ar autops perform	v .	prior to co death?	opsy findings available impletion of cause of
Vital	Physician: this certificanal director,	Be	25. Was case referred to medical examiner?				of Death (Ch	eck only on	θ)		
of	Hospital: Impatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify)  1 Yes 2 No Hospital: Impatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify)  27. Manper of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred									(y)	
Work?    Month, Day Year   Injury   Work?    Month, Day Year   Injury   Work?    Month, Day Year   Injury   Work?									w injury o	ccarred	
Division of	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	rm, str	eet, factory, of	ffice		ocation (Str City or Town		lumber or Rura	al Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge of the control of the basis of examination and manner stated.	dor inv	occurred at the stigation, in	he time, date and my opinion, deat	d place, and o	lue to the ca the time, da	use(s) an	d manner as s ace, and due to	stated. or the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		( )	icense number	- /	29	d. Date s	igned (Month,	Dey, Year)
	0		· / / N			005130	11		90	1 66	, 2006
7	)		30. Name and address of person who completed cause of death (Item 23a)  Keyn B Kwpt GOO Berryg	Туре,	Print)	An	ng po	115 1	16	2/4	>
	Sta Regist		31. Date filed (Month, Day, Year)  JUN 0 5 2006	204	Es		/				
			JUN O 9 TOOR MENSOR								

06-03501 Whitney Wiley

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar  Certificate of Death Reg. No. 2006 1757					
Physicia	an/	Decedent's Name (First, Middle, Last)	Date of Dea     Month	Day Year 1545 has	
ledical Exami	ner	Whitney Lashae Margaret  4a. Facility Name (if not institution, give street and number)  4b. C	Wiley May 23, 2	1545 hrs	
Sinai Hospital  Baltimore					
Funeral		5 ( )		rth(MM/DD/YYYY) 9 Birthplace (State or	
Director		215-27-2222 1 M 2 XF 19 Yrs. N	fonths Days Hours Min.	2 86 Foreign Country) MD	
<i>x</i>	ļ	Usual Residence of Decedent			
ow any		1 v Yes 2 No			
daryland 28a-f show 1 at once.	턍	MD NA Baltimore		log. Citizen of What Country?	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mertal Hygiene, it is narked other than "naturalt", or items 33a or 28a-f sho ratic event, the Medical Examiner must be notified at once.	Director	2432 Everton Road Apt A	21209	U.S.A.	
		11. Marital Status 12 Was Decedent Ever in U.S 13. Was De	cedent of Hispanic Origin? (Specify Yes or No specify Cuban, Mexican, Puerto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc	
or ites	Funeral	1 Yes 2 X No	•	D 3 1-	
hours afte 'natural'', Examiner	<u>S</u>	or Dates:	s 2X No specify:  Isual Occupation (Give kind of work done	Specify: Black  16b. Kind of Business/Industry	
72 hou	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	of working life DO NOT use retired)		
036 vithin vithin ene.	di	l	nployed	Unemployed	
15-0 filed v Hygi d oth	Be C	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle, Claudett Dar		
21215-0036 unld be filed within 7 Mental Hygiene. marked other than c event, the Medica		Lonnie W. Wiley  19a Informant's Name/Relationship (Type, Print)  19b. Mailing Ad	dress (Street and Number or Rural Route Nu	mber, City or Town, State, Z <sub>i</sub> p Code)	
MD 2 shorth and 27 is umatic		Claudett Dargan-Mother 2432 I	Everton Road Apt A	, Balto, Md 21209	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is narked other than injury or other traumatic event, the Medical		20a Method of Disposition  1 XBurial 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or other process.		20c. Location - City or Town, State	
imo Pages nento ant:		4 Donation 5 Other Specify: Druid Ric		Pikesville, Md	
3alt ermit Departr mport njury		Marc	e and Address of Facility Ch F/H West		
Physician	4300 Wabash Ave, Baltimore, Md 21215  23a. Part I. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Approximate Interval				
/Medical	failure. List only one cause on each line.  Between Onset ar  Death  Death				
Examiner	ìij	or condition resulting in death)  Due to (or as a consequence of).  Sequentially list conditions,			
·	ايرا				
	cause. Enter Underlying Cause				
ed	Exal	events resulting in death) Last  Due to (or as a consequence of):			
760, cate be executed physician and the burial - transit	ical	UNPENDED AMENDED			
760, cate be physic he burn	Medical	IF FEMALE 23c. If yes, outcome of pregnancy		23d. Date of delivery	
cox 687 eath certifit attending for use as t	ian/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (Specify)			
Box 68760, he death certificate be the attending physic ned for use as the burned for us	Physician	1 Yes 2 No 9 Unknown 9 Unknown			
ies that the d signed by the	b	Part II. Other significant conditions contributing to death but not resulting in the under	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	obacco use contribute to the cause of death?	
S, P uires t n signe Id be d				s 2 V No 3 Probably 4 Unknown  1 24b Were autopsy findings available	
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tal Records ian: The law requ certificate has been	Completed	1 V Yes 2 No 1 V Yes 2 No			
- S - E	Be	25. Was case referred to medical examiner?  1  Ves 2 No. Hospital: 1 Inpatient 2 ER/Outpatient 3	26 Place of Death (Check only one)  Other Wursing Home 5	Residence 6 Other	
n of V ding Phys After thi funeral di	유 ::	27. Manner of Death 28a. Date of Injury 28b. Time of Injury	y 28c Injury at Work? 28d Describe	how injury occurred	
ision of Attending of Gentlemann of Gentlema	tior	1 Natural 5 Pending 2 Accident Investigation  Natural 5 Pending FOUND: May 23, 2006  FOUND: 0315 hrs	1 Yes 2 ✓ No Subject sho	ot	
IVISI or Att after d Direct	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fa	or Town,		
DIVI Hospital or 224 hours after Funeral Dir	Ser	4 Homicide determined (Specify) unknown unknown, Baltimore, MD  29a. Certifier 4 Continue Physician. To the best of my knowledge, death accoursed at the time date and place, and due to the cause(s) and manner as started			
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	(Check only one of the control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)			
To To	Med	and manner stated  29b Signature and title of sertifier	29c. License number	29d. Date signed (Month, Day, Year)	
		1 D chouse	O.C.M.E.	May 25, 2006	
		30. name and address of person who com and cause of death (Item 23a)			
H	Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201				
State 31. Date filed (Month, Day, Year)  Registrar  11.10 ( 5 2006					
DHMH 17 Rev 1/2001		ORIGINAL			

DHMH 17 Rev 1/2001 OCME 2006

Amend Item 8 per FH,G856,06/05/05dhb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** WHITAKER MAY 2006 KENNETH 28 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore
H Under 1 Year | If Under 24 Hrs. onvelescen. ently 8. Date of Bir 8/08/1963 irthplace (State or Foreign (Month, Day, Year) 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** 1**X**M 2□F Days 217-68-0826 Director 2006 NEW YORK Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "natural", or items 23s or 28s-f show other traumatic event, the Madical Examinar must be nutified at 1XYes 2□No Director MD TIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21218 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after if Hygiene. other then "natural", or ite Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify δ 3 ☐ Widowed 4 Divorced Specify: BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Efementary/Secondary (0-12) College (1-4or 5+) SPICE 12 FORKLIFT OPERATOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Pages 1 and 2 should be fil tment of Health and Mental H tant: If Item 27 Is marked oth Be IAMES LUCILLE WHITAKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 833 BALTO, MD 21218 BONAPARTE MOTHER LUCILLE WHITAKER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Depertment o Important: If eny injury or injury or JUN 3,2006 Balto TRINITY CEMETERY 4 □Donation 5 □ Other (Specify) Service Pit 21. Signature of Funeral Service License Calps 1701 Mc Culloh 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner PHALOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of) signed by the attending physicien and d be deteched for use as the burial-transit Exam Due to (or as a consequence of) Box 68760. Physician/Medicai fF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. 9☐ Unknown 9 Unknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Uhrknown peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No has autopsy certificete 1 ☐ Yes 2 No Division of Vital the funeral director, 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient ٩ 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? ne Hospitel or Attending P n 24 hours after death. ne Funerel Director: After t After 1 Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the 29b. Signardre and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 2 0 06/02 Place. Dundalk. MD 21222 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) a 31. Date filed (Month, Day, Year) Registrar's Signature State JUN 0 5 Registrar 2006

			1 - For State Registrer	State of Ma	-			lealth ar Death	nd Me	-	giene, Reg. No.	2006	17574
			1. Decedent's Name (First, Middle, Last)							2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medic		Felix H. Zoep	ofl						May	31	2006	10:10AM
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City	, Town, or	Location of	Death			County of Death	
			Knollwood Manor			-		ville				ine Arur	
	Funeral		5. Social Security Number 6. Sex	IM 2DE	(In yrs. last birthday, Yrs.	Months	Days	If Under 24 Hours	Min	<ol> <li>Date of Birt (Month, Da</li> </ol>	v Year)	Cor	place (State or Foreign Intry)
	Director		215-09-9535 Usual Residence of Decedent	9	115.			<u> </u>		April '	15, 1	915 Mar	yland
	and wo		10a. State 10b. County		10c. City, Town or L	ocation							10d. Inside City Limits
	f sho	ō	Maryland Anne Aru	ndel	Odenton								1 ☐ Yes 2X No
	28a	rec	10e. Street and Number			10f. Z	p Code				10g. Citiz	en of What Cou	untry?
	3a ol	Funeral Director	490 North Patuxent	Road #4	9		2111	3			U	nited S	tates
	death	Jers		12. Was Decedent Ev	ver in U.S. 13.	Was Deci	edent of H	ispanic Origi	in? (Spec	ofy Yes or No- tican, etc.)	- 1	4. Race - Amer	
9	or its		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes		Specify:	Pueno n	iican, etc.)		Black, White Spec <i>ify:</i> Wh	nite
ဋ္ဌ	ours ral',	dby	3 X Widowed 4 □ Divorced	Year or Dates:		1 1 1 1 1 1 1 1 1 1	220 110	эрөспу.				speciny:	
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Maryland 21215-0036	ntal hed of	Be	Anton Zoepfl							Hoelbi		ourname)	
2	2 should be tiled within 72 hours after death with the Maryland and Mental Hygiene.  is marked other than "natural", or iteme 23s or 28s-f show aumatic event, the Madical Exami armust be notified at	ဍ	19a. Informant's Name/Relationship (Tv.	ne Print)	19h Maili	na Addres	s (Street	and Number	or Bural	Route Numbe	er City or	Town, State, Zi	p Code) 21113
<u>8</u>	id 2 s ith an 27 is trau		Stephen L. Zoepfl			-						ton, Ma	,,
<u>ق</u>	Hee tem		20a. Method of Disposition		20b. Place of Disp	osition (Na	me of	1	Da			ation - City or T	
9	Pages nent of h int: it its ury or of		1 X Burial 2 ☐ Cremation 3 ☐R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, cre	-		1	:/2/2	2006	D-1+	-i moreo	Maryland
altimore,	ertm ortar		21 Sign wure Funeral Service License	99				s of Facility					
ä	permit. Pages 1 and 2 should by Depermit. Department of Heelih and Menta important: If item 27 is marked any injury or other traumatic s. 2002.	E (6	人ンノルスト			107	Wilke	ens Ave	нио enue	oard Fi . Balti	lmore	l Home, , Maryl	and 21229
			23a. Part1. Enter the disease, or compli	cations that caused t	he death. Do not en							,	Approximate Interval Between
	Physician		shock, or heart failure. List only or Immediate Cause (Final	e cause on each line		20:0	le mi	à - 1/G	ic. f.	Liger	. 0		Onset and Death
}	/Medical		disease or condition resulting in death)	Due to (or as a	consequence of):				-/ 4(	,			600
п	Examiner		Sequentially list conditions,										
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œ	physics the t	dical										-	
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	that	by Pr	Part II. Other significant conditions con	tributing to death but	not resulting in the u	inderlying	cause give	en in Part I.		23e. Did to	bacco us	e contribute to	the cause of death?
Records,	w requires that been signed t should be det	d b	Iteel vlu							1 🗆 Y	'es 2 🔄	Helo 3 □ Pro	bably 4 Unknown
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	<b>hysician:</b> The law nis certificete has I director, page 2 s	Completed									rmed?	death?	ompletion of cause of
ta		0	25. Was case referred to medical					26. Place o	of Death	1 ☐ Yes (Check only o	2 2110	1 🗆 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 140
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0	ding Phy h. After thii funeral c		27. Manner of Death  i ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	of	28c. Injury Work	at	28	d. Describe	ow injury	occurred	
<u> </u>	Attending Physician: r death. sctor: After this certifice by the funeral director.	atic	2 Accident investigation			М		Yes 2 □ No	0				
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	urs e arai C	ပ္	00- 0	<u></u>								<del></del>	
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	To the Hospital or Attenwithin 24 hours effer deati To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier				c. License					signed (Month,	
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	10		30. Name and address of person who co	mpleted cause of dea	ath (Item 23a) (Type,	Print)			~			- / - /	000
	( )			rure a	2/071),	1200	ato	Drie	مو	Chart	~ M	1791	019
P	Sta		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	beech	0	•					
美	Registr	dl'	JUN 0 5 2	UUU JUU		9							

		For Amend Item#1:	State of Mai				-	_	06	-	575
Physic	ian	1. Decedent's Name (First, Middle, La	est)		runcate or	Deatri	2. Date of Death Month		0 <sup>Year</sup>	3. Time (	
/Medi		JAMES GEOR						T		6:57	A M
Exami	ner	4a. Facility Name (If not institution, give				or Location of Death			ty of Deat		
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Funeral Director			1 <b>X</b> M 2□ F 74	Yrs.	Months Days	Hours Min.	Month, Day, DEC 19 1	931	Co	YLAND	
land ow		10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside (	City Limits
Many a-f sh	tor	MARYLAND ALLEGANY	Z	FROSTBU	JRG					1x Ye	s 2 No
death with the Maryland rms 23s or 28a-f show rmust be nutified at	Directo	10e. Street and Number	.,		10f. Zip Code		10	g. Citizen o	What Co	untry?	
23e		180 ORMOND STRI	EET		215			U.S.			
- i # #	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:	1951-55	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	BI	ace - Amer ack, White ify: WH		•
2 hou		15. Decedent's E	ducation	16a, Dece	dent's Usual Occup	pation	1	6b. Kind of	Busigess/J	ndustry	
within 7:	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed)  College (1-4or 5+)	(Give	kind of work done DO NOT use retire FEACHER	during most of world)	king		JCATI		
Id 212 s filed within I Hygiene. other then		17. Father's Name (First, Middle, Last	")			18. Mother's Nam	e (First, Middle, M	laiden Suma	ime)		
ed at be	To Be	DAVID T. ADAMS	,				NIE JOHN			S	
re, Maryls s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (CAROL C. ADAMS	(Type, Print)			TREET, FE		-		ip Code)	-
nore, Nages 1 and of Health if item 27 or other tr		20a. Method of Disposition		20b. Place of Dispo cemetery, cre				Oc. Location		Fown, State	
0 00		1 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Speci		FROSTBURG		1	2-06 F	ROSTBU	IRG M	D	-
Baltimore, permit. Pages 1 a Department of Hea Importent: If item any injury or othe		21. Signature of Funeral Service Lice	**		2. Name and Addre			W. M.			
n gallag		Alen 3n =	Severs m	100547 81	OWERS FUN	ERAL HOME	, P.A. F	ROSTE	JRC M	D 2153	12
Physician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Endst	Age C		ng, such as cardiac	or respiratory arre	st,		Approxima Interval Be Onset and	etween
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uted ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):							
6 be executed sician and burial-transit		resulting in death) Last	Due to (or as a	consequence of):							
<b>68/</b> (ifficate the physical graphysical graphysical graphysical graphysical graphysical graphysical graphysical graph graphysical graph gr	dlcal		_ d								
BOX lath cert attendin for use	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal death 3	□Ectopic pregnance □ Other (specify)	y			ate of deli-	very Day	Year
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Cords, P.O wrequires that the been signed by th should be detache		Part II. Other significant conditions	contributing to death but	not resulting in the u	inderlying cause giv	ren in Part I.	23e. Did toba	acco use con s 2 🗆 No			death? Junknown
VITAI HECOFTS sicien: The law requires certificate has been sign	ompleted						24a. Was an autopsy perform	ed?	death?	opsy findings ompletion of	s available cause of
VITAI	C	25. Was case referred in medical				26. Place of Deat	1  Yes 2 h (Check only one		1 L Yes	2□ No	
	To B	examiner? 1 Yes 2 No	Hospital: 1  Inpatient	2 ER/Outpatier	nt 3 DOA Oth	er: 4 🗌 Nursing Ho	me 5 esider	ice 6 🗆 Oi	her (Spec	ify)	
C & e	:io	27. Man of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day )	Year) 28b. Time o	f 28c. Injur Wor		28d. Describe how	v injury occu	rred		
VISION ( Attending F or death. ector: After by the funera	catl	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 No					
UIVISION  al or Attending b after death. I Director: After d in by the fune	Certification:	4 Homicide determined		y - At home, farm, str (Specify)	reet, factory, office		28f. Location (Stre City or Town,		iber or Rui	ral Route Nur	nber,
To the Hospital or At within 24 hours after or To the Funerel Direct completely filled in by	edical 0	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	nysician: To the best of miner: On the basis of e and manner state	xamination and/or in	h occurred at the tir vestigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, dai	use(s) and n te and place	nanner as , and due	stated. to the cause(	(s)
To the within To the comple	Me	29b. Signature and title of certified	1 - 2.	A .	29c. Licens	_	1	/}		, Day, Year)	
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1 1	1	On Name and statute to the	andanthical	Ale (Hann and )	D=(=4)			1	1		
V		30. Name and address of person who	//		1	E. CHMRED	T.AND NEW	/	,		
Sta Regist	ate	30. Name and address of person who GARY L. WAGONER.  31. Date filed (Month, Pay, Year) 5 2005	M.D., 925	BISHOP WA	ALSH DRIV	E, CUMBER	LAND, ME	/	,		

			1 = For State Registrar	State of		nd / Depa		t of H	ealth a		lental Hy	Reg. No.	2006	17576
	Physicia	an a	Decedent's Name (First, Middle, La Bernard	G.		Androul	akis				2. Date of Dea	Day	Yeer	3. Time of Death
	/Medic					Midrodia	,	Tours or	Location o		May 16, 2		unty of Deetl	6:20 A M
1	Examin	er	4a. Fedility Name (If not institution, git		nber)				Height				ince Geo	
			2825 Colebrooke Driv 5. Social Security Number 6.		7. Age (In yrs.	last birthday)	If Under	1 Year	If Under 2	24 Hrs.	8. Dete of Birt		9. Birth	hplace (State or Foreign
6,3	Funeral Director			1⊠X4 2□F	84	Yrs.	Months	Days	Hours	Min.	8. Dete of Birt 9/30/19	21 <sup>Yeer)</sup>	Wash	ington,DC
	D .		Usuel Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Le	ocation	-						10d. Inside City Limits
	Maryla f sho	o	Maryland Prince Ge	orge!s	I	Hillcres	t Heiol	nts						1 ☐ Yes 2 ☐ No
	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at any once.	Funeral Director	10e. Street and Number 2825 Colebrooke Driv			micia	10f. Zip		48			10g. Citizen	of What Co USA	untry?
	death	nera	11. Marital Status	12. Was Dece Amed For	dent Ever in U	J.S. 13.	Was Deced	dent of Hi	ispanic Orig	gin? (Spo	ecify Yes or No Rican, etc.)	- 14.	Race - Ame Black, White	
920	ours after ral', or Ite Examine	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∑Yes	<sup>2 □ No</sup> WWI ates: Korea	I	1 ☐ Yes	2[ <b>X</b> No	Specify:			- 1	ecity: Whi	
Maryland 21215-0036	thin 72 ho e. an "natur Medical	Completed	15. Decedent's E (Specify only highest gi	ducation rade completed) College (1	-4or 5+)		dent's Usua kind of wo DO NOT us						of Business/	
7	ed wi	Con	11th			Weight	s and I	Balanc		_			1 Gover	nment
land	uld be file Mental Hy irked oth	To Be	17. Father's Name (First, Middle, Las Michael J. Androulak								(First, Middle, C. Barnes	Maiden Su	mame)	
Man	2 sho		19a. Informant's Name/Relationship				-				ai Route Numbe st Height			Tip Code)
e, P	1 and Health Fm 27 ther t		Bettie W. Androulaki 20a. Method of Disposition	s/wrre	20b.	Place of Disponentery, cre					Date		ion - City or	Town, State
nor	eges int of h t: if ht y or o'		1 Burial 2 Cremation 3		State	cemetery, cire .as Crem		ther plac		5/20/2	2006		ter,MD.	
Baltimore,	permit. P Departme Importan any injuri once.		21. Signature of Funeral Service Lice	A	,	2	2. Name ar	nd Addres	ss of Facilit	yGeor:	ge P. Kal on Hill,	as Fune	eral Hon	ne P.A.
,09	Physician /Medical Examiner  physician and p	Icai Examiner	23a. Part / Enter the disease, of coshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitleted events resulting in death) Last	Due to (	or as a consector as	quence of):								Onset and Death,
P.O. Box 68	at the death certificate by the attending physicached for use as the botached	by Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		irth 2 ☐ Fet ant at time of	el death 3	⊒Ectopic p □ Other (sp					230	I. Date of deli Month	ivery Day Year
	uires that signed b		Part II. Dther significant conditions	contributing to de	eath but not re	sulting in the	underlying o	ause giv	en in Part I		23e. Did t			the cause of death?
Division of Vital Records,	sician: The law requires that the certificate has been signed by th irector, page 2 should be detache	Completed									24a. Was autoj perfo	osy ormed?	prior to death?	itopsy findings available completion of cause of
/ita	clan: ertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Oth	0.0		h (Check only o			
of	Physic this c	To.	1 Yes 2 No 27. Manner of Death			ER/Outpatie		OA Oth	4 🗆 140	-	me 5 Resi			cify)
on	ding f h. After funer	tion	1 XXIatural 5 Pending 2 Accident investigat		of Injury th, Day Year)	Injury	м	Wor	k? Yes 2□					
Divisi	or Attending Physician: after death. Director: After this certific I in by the funeral director,	Certification:	3 Suicide 6 Could not determine	be 28e. Place	of Injury - At I	home, farm, s	treet, factor	y, office			28f. Location ( City or To		lumber or Ru	ural Route Number,
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) ,	, 7		1 ) or	5/6		mo		D5	994	2		5	117/2	006
ck	-8		30. Name and address of person wh	-	O .	om 23a) (Type		rd	Rocal	#2	of Cle	when	MB	20736
	St Regist	ate rar	31. Date filed (Month, Day, Year)  MAY 1 9 200	2. F	Registrar's Sign		R.	,						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND#10gperFH5/19/06, RMW, MoCo Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 14:09 Pm **Physician** DANIEL AWMAHBOATENG KWAME 2006 05 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES HOSPITAL CHEVERLY PRINCE GE ORGES 7. Age (In yrs. last birthday) II Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1948 KYWASI, CHANA , Funeral 1 M 2 □ F 577823725 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at 1 Yes 2 No PRINCE GERGES FOREST VILLE Director MO 10g. Citizen of What Country? U.S.A.10f, Zip Code 10e. Street and Number AMERICANI 1752 FOREST PK 20747 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other then "natural", or Ite 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐No 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) TAXI CAB DRIVER TAXI CAB PRIVER 18. Mother's Name (First, Middle, Maiden Surname) Be DORA KINGSLEY AWUAH BRETTEN 1086 TRAVIS LANE GAITHERSBURG MO, 20879 19a. Informant's Name/Relationship (Type, Print) BERNARD K. AWUAH ..r. Pages 1 a. Jepartment of Health Important: If Ite-eny injury. 20a. Method of Disposition

Burial 2 □ Cremation 3 ▼Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 7/1/2006 Asaman Kumasi, Ghana 4 ☐ Donation 5 ☐ Other (Specify) Asaman Cemetery 21. Signature of Funeral Service Vicensee 22. Name and Address of Facility Hines Rinaldi Funeral Home 11800 New Hampshire Ave Silver Spring, MD 20904 23a Part I. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Marsive infourvance **Physician** /Medical Due to (or as a consequence of): Examiner Hypertención Sequestially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□PregnanI at lime of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Deaherter mellitus 1 Yes 2 No 3 Probably 4 Unknown Completed Rena 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Confestive 1 Yes 2 No heart 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. 28d. Describe how injury occurred 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Sutcide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifler 00043662 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.C, How 3001 Hospital Drive Cheverly, Maryland William Boyce 20785

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY

2006

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 21 4:35 AM May 2006 Angleberger /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Frederick Frederick Frederick Memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 DA 89 214-10-4797 February 25, 1917 Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. fnside City Limits 10a. State 10b. County worle ?7 ie marked other than "natural", or iteme 23a or 28a-f ehov treumatic event, tre Medical Exeminar must be notified at Frederick Frederick 1 Yes 2 No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 1820 Lathan Drive U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritaf Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mentai Hygiene. Important: if Item 27 ie marked other than "natural", or Item any injury or other treumatic event, the Medical Examinary once. Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify. 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Proofreader **Business Forms** 18. Mother's Name (First, Middle, Majden Sumame, 17. Father's Name (First, Middle, Last) Be Nannie C. Wachter Roy Edgar Weller ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2005 Fire Tower Lane, Ijamsville, Maryland 21754 Lela Weaver - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Blue Ridge Cemetery 5-25-2006 Thurmont, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Sign ware of Funeral Service Licensee Maron 1621 Opossumtown Pike, Frederick, Maryland 21702 lue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hepatitis

Due to (or as a consequence of): **Physician** Days /Medical Examiner weeks ymphoma Sequentially list conditions, if any, leading to mini-adiata cause. Enter Underlying Cause (Disease or injury Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4☐ Pregnant at time of death ed by the a 9 Unknown 9 Unknown ate has been signed page 2 should be det Part fl. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: ↑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₺ No 2 this 27. Manner of Death 1 Natural 28c. Injury at Work? Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death ornamed at the time, date and place, and due to the name(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) npletely (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D62180 May 21, 2006 30. Name and address of rerson who completed cause of death (Item 23a) (Type, Print) 400 W.Est 7th St, Frederick MD 23 2006 State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Yeer **Physician** Donald Bourgeois 6.40 PM 17th 2006 -ours 05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Westminster Hospita Carroll ATTOL If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) July 15, 1951 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** Months Hours 1 M M 2 □ F 54 Germany Director 230-74-9134 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be motified at 1 ☐ Yes 2 No Director Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 USA 216 Garden Way death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. e filed within 72 hours after of Hygiane. I other then "naturel", or Iter 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 2 Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **GMAC** Mortgage Officer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be in ment of Heelth and Mental I ant: If Item 27 Ie marked of Donald Bourgeois Unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Westminster, MD 21157 Wife 216 Garden Way Michele Bourgeois 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Depertment of Important: if eny injury or once. 5/19/06 Hampstead, Maryland Carroll Cremation Inc 4 □Donation 5 □Other (Specify) 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 21. Signature of Funeral Service Licensee 412 Washington Rd. Westminster, MD 23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediale Cause (Final Bactena nhemonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed ed by the attanding physicien end detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did lobacco use contribute to the cause of death? ۾ cate has been signing Liver End nue 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an within 24 hours after death.

To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2 is 1 ☐ Yes 2√No To the Hospital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: 1 ➡Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 25 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🖼 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 17/06 437 Westminister MD 21157 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rid de (ALIMUUD 31. Date filed (Month, Day, Year) 32. egistrar's Signature State MAY 1 9 2006 Registrar

		1	For State Registrar		State o	f Marylan				ealth a Death		F	Reg. No.	2006	17580
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40	Examin	er	SPRINGBROOK N				ENTER			SPRIN					ONTGOMERY
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	10		30. Name and address of pers	on who car	mpteted cau	se of death (Ite	me3a) (Type	, Print)							
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	Funeral Director		5. Social Security Numb 480–18–8677	7	Sex 1 ☐ M 2 <b>½</b> ② F	7. Age (In yr.	s. last birthday, Yrs.	Months		Hours	Min.	8. Date of B (Month, D Sep 17	irth (ay, Year) 191	6	Country IOW	ce (State or Foreign 7) 7a
	and wo	-	Usual Residence of Dec 10a. State 10	b. County		10c. 0	City, Town or L	ocation							10d	. Inside City Limits
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	be filed within 72 hours after death with the Maryland stat Hygiene. of other than "naturel", or iteme 23a or 28a-f ehow event, the Madical Examinat munt by multiped at event.	۵	10e. Street and Number 820 Hughe		Road			10f. Zip	Code	2115	8		10g. Citi	zen of What		1?
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			23a. Part . Enter the d shock, or heart fa	disease, or con	nplications that	caused the de	ath. Do not en	iter the mod	le of dyin	g, such as	cardiac o	or respiratory	arrest,		A	pproximate nterval Between
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<u> </u>	Physician: this certificatal director, a	To B	examiner?		Hospital: 1 [	Inpatient 2	☐ ER/Outpatie	ent 3 🗆 D	OA Oth	er: 4 Nu	ursing Ho	me 5 Re	sidence	6 🗆 Other (S	Specify)	
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Brown

10c. City, Town or Location

7. Age (In yrs. last birthday)
77 Yrs.

4b. City, Town, or Location of Death Charlotte Hall

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

2. Date of Death

8. Date of Birth
J.Month 9 ay 1 928

May 17,

Day

4c. County of Death

St. Mary's

2006

Certificate of Death

3. Time of Death

6:25 A

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 No

Washington, DC

	Ragistrar		
	1. Decedent's Name (First, Midd.	le, Last)	
Physicia /Medic	George	Leslie	3
Examin	4a. Facility Name (If not institutio	n, give street and nu	ımber)
	Charlotte Hall V	eterans Home	9
Funeral Director	5. Social Security Number 577–34–5345	6. Sex 1XQXM 2☐ F	7. Ag
	Usual Residence of Decedent		

For State

10a. State

10b. County

or than "natural", or Itema 23a or 28a-f show the Medical Examinar must be notified at h and Mental Hygier 18

Maryland Prince George's Berwyn Heights Director 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 6225 Seminole Place 20740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X3XYes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Never Married 2 ☐ Married 1 ☐ Yes XX No Specify: White Baltimore, Maryland 21215-0036 δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Electrician 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fil ment of Health and Mental H lant: If item 27 is marked ott jury or other traumatic even Zenaida May Bailey Leslie Christy Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marjorie J. Hathcock / sister 6225 Seminole Place Betwyn Heights, Paryland 20740
of Disposition (Name of Date 20c Location - City of Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State permit. Page Department c Important: If any injury or once. Kalas Crematory Edgewater, Maryland 4 □ Donation 5 □ Other (Specify) 5/18/2006 22. Name and Address of Facility Geo. P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 21. Signature of Funeral Service Licenses da 23. Pa/1. Enter the diseas, or complication, hat crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arrhythmia Cardiac Physician /Medical Due to (or as a consequence of): Carchio Vasculas diseas Examiner sclerotic thero Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical as the t IF FEMALE: use a 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year ò in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Munknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed b Division of Vital Records, þ Obstruct hive 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Completed Hyperlipidems 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Jursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 10 Sir. After this funeral d 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide hours after ö hin 24 hours a the Funerel C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and true of certifier 0 D50653 5-17-2006 GYAIY - C. SURANA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) church ton Decele 5851. Road. Deale 31. Date filed (Month, Day, Year) State MAY 1 9 2006 Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

		1	For State Registrar	State of Maryland / De	epartment of H Certificate of L			ene g. No. 2 () () ()	17583
I	Physicia		1. Decedent's Name (First, Middle, Last)  Earle Willa	cd Brown		2	Date of Death Month May	Day Year 18 2006	3. Time of Death 4:15 P M
	/Medic Examin	al -	4a. Facility Name (If not institution, give s			r Location of Death	Huy	4c. County of Death	
			88 Abbyshire Rd.	7 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	Ocean P		Date of Righ	Worcester	
	Funeral Director		5. Social Security Number 6. Sex 1X	M 2□ F 7. Age (In yrs. last birtho	Months Davs	Hours Min.	Date of Birth (Month, Day, 27)	,1923 MD	place (State or Foreign ntry)
	pur *	H	Usual Residence of Decedent  10a, State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	Maryla -f aho		MD Worcester	o Ocea	n Pines				1 ☐ Yes 2 🙀 No
	or 28s	Oirec	10e. Street and Number		10f. Zip Code			g. Citizen of What Cou	ntry?
	ath wi	ral	88 Abbyshire Rd.	10 IN- 0 - 1-1 5 - 1 1 C	21811	lianania Origin? (Speci		JSA 14. Race - Amer	ican Indian
39	urs after de Ni', or itami	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1X☐Yes 2☐No WWII If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	can, etc.)	Black, White Specify: Whi	, etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental tyglene. Department of Health and Mental tyglene important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow important: if item 27 is marked other than "natural", or items 20 or 28a-f ahow appring to the traumatic avant. The Medical Examinar must be notified at ance.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	completed) (9 College (1-4or 5+)	Decedent's Usual Occup Give kind of work done life. DO NOT use retired	during most of working He	alth	6b. Kind of Business/I	
d 21	filed w Hygiel Other t	CO	17. Father's Name (First, Middle, Last)	5+ Dir	ector of Er	18. Mother's Name (		Universit Maiden Sumame)	.у
lan	should be and Mentai marked o	To Be	Julian Oliver Bro			Ethel Rose			
Maryland	12 sho h and I 7 is ma	i	19a. Informant's Name/Relationship (Ty		Mailing Address (Street Abbyshire				ip Code)
	Healt Healt tem 2		June M. Brown (wi	20b. Place of D	Disposition (Name of , crematory or other place	Da		20c. Location - City or T	own, State
<u>E</u>	Pages nent of ant: if i		1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State Arlingt	on Natl. Ce	em.  7-19-2	2006 A	Arlington,	Virginia
Baltimore,	permit. Departr Importa any inje		21. Sign up of Funeral Service Library	usan Moorsy	22. Name and Addre	iam St., Be	erlin. N	ge Funeral Md. 21811	Home
	Physician		23a. Part 1. Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition	ications that caused the death. Do not not be cause on each line.	ot enter the mode of dyir	ng, such as cardiac or	respiratory arre	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of Anterioscience	): Cn -	2 - 4 - 5 - 4	.12	2.5.20	
		Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	1):	DIOVASCU	WINC	DISEFFIE	
	ate be executed hysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	Due to (or as a consequence of	f):				<del></del>
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.O. Box 68	death certific e attending p ad for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 4   Pregnant at time ol death 9   Unknown	3 ☐ Ectopic pregnance 5 ☐ Other (specify)	у		23d. Date of deli Month	very Day Year
s, P	Se G	by	Part II. Other significant conditions co.	ntributing to death but not resulting in	the underlying cause giv	ven in Part I.	23e. Did tob	es 2 □ No 3 □ Pro	the cause of death?
Record	e law has b	Completed					24a. Was an autops perform	v prior to c	topsy findings available completion of cause of
Vital	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?	1 150	1 04	26. Place of Death	Check only on	9	
o	ling Phys	2	27. Manner of Death 1 XNatural 5 Pending	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	ime ol 28c. Injury Wo			once 6 Other (Special of the Control	ufy)
Division	or Attantiter deat irsctor: n by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, lar building, etc. (Specify)	m, street, factory, office	21	BI. Location (St. City or Town	reet and Number or Ru n, State)	ral Route Number,
	To the Hospitel of within 24 hours at To the Funers! Completely filled it	Medical C	29a. Certifier  (Check only one)  1 Certifying Phy 2 Medical Exami	sician: To the best of my knowledge, iner: On the basis of examination and and manner stated.	death occurred at the to	ime, date and place, ar opinion, death occurre	nd due to the ca d at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Ž	29b Signature and title ol certifier	20-	29c. Licen:		1	9d. Date signed (Monti	4
		1	Usnea	er O'	JUAN Brist	645+		2/19/2	2006
5. A	5+1			IENA, MD 1032	D4 Type, Print) 24 020 000	PANCITY	BUND	Boxer,	U021811
	St Regist	ate trar	31. Date liled (Month, Day, Year) MAY 2 2 2	32. registrar's Signature	pode				

Physi /Med Exam

To the Hospital or Attending Physicien: The law requires thet the death certificate be executed within 24 hours after death.

To the Funersi Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

		1 - For State Registrar	Otate of			Certificate			vicintai i	Reg. No		1/5	84
Physici	an	1. Decedent's Name (First, Middle,							2. Date of Month	Da		3. Time of Dea	
/Medic			oley Bowm						May		2006	12:51 I	РМ
Examin	er	4a. Facility Name (If not institution,						Location of Death		40	. County of Death		
		Calvert Memoria 5. Social Security Number		Age (In yrs. /	lact hirth			Frederic  If Under 24 Hrs.		Righ	Calve	ert oplace (State or Fo	
uneral rector		578-24-2663	1 <b>∑</b> M 2□F	79	Yı	Months		Hours Min.	8. Date of (Month, Marc	h 20	1927	Virginia	reign
* =		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town	or Location						10d. Inside City Li	imits
a b	ō	MD Ca	lvert	H	iinti	ngtown						1  Yes 2 <b>∑</b>	No
289	rec	10e. Street and Number	021020		<b>G</b>	10f. Zip (	Code			10g. Ci	tizen of What Cou	untry?	
23s of	Funeral Director	30 Hoile Lane						20639			USA	,	
E LI	ner	11. Marital Status	12. Was Decede		S.	13. Was Decede	nt of H	ispanic Origin? (S an, Mexican, Puert	pecify Yes or o Rican, etc.)	No-	14. Race - Amer Black, White		
important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Marrie 3X Widowed 4 ☐ Divorced		□ No		1 ☐ Yes 2		Specify:				White	
alcat	Completed	15. Decedent's (Specify only highest			(	Decedent's Usual Give kind of work	done	during most of wor	kına	16b. K	(ind of Business/l	ndustry	
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E E		17. Father's Name (First, Middle, Li				Branch	Mar	18. Mother's Nan	(55) 141-4			rance Co.	•
ed of	Be	Floyd	151/	,	Powr	on				ole, Malger	•	202000	
mark	은	19a. Informant's Name/Relationshi	n (Type Print)	•	-		Stroot	Myrtl and Number or Ru		nhar City		perger	
27 is trau		Joseph M. Flor		n-law)				Hunting			20639	p Code)	
tem		20a. Method of Disposition	24 (5011 2			Disposition (Name, crematory or oth			<sup>Dal</sup> 19		ocation - City or T	Town, State	
tant: If i		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	ecify)			.ckson Ce	met	ery 20	006	Mt	. Jackso	on, VA	
eny ir		21. Signature of Fungral Struct Li	Lee			22. Name and 8125 Sc		<sup>ss of Facility</sup> Le nern Mary			Iome Calv		736
ovician and sold in the purial-transit	Medical Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or Due to (or c.	OCA as a consequ	A R	Y A		INFA			4		th -S·
To the Funeral Director; After this certificate has been signed by the ettending placompletely filled in by the funeral director, page 2 should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ∏ Fetal ntat time of de	death	3 ☐ Ectopic pre- 5 ☐ Other (spe-		,			23d. Date of delin Month	very Day Year	r
n signed b Ild be det	þ	Part II. Other significant condition  DIABETES	s contributing to dea		-		use giv	en in Part I.		d tobacco		the cause of death	
ate has bee page 2 sho	Completed	DYSLIPIDA	AEMIA						pe	as an itopsy informed? s 2 No	prior to co	opsy findings avai ompletion of cause 2 \square	lable e of
ertific octor,	Be	25. Was case referred to medical examiner?						26. Place of Dea	th (Check on	ly one)			
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the the	icat	2 Accident investigat 3 ☐ Suicide 6 ☐ Could no	t be 390 Place o	f Injuny - At ho	me fam	m, street, factory,		Yes 2 □No	28f. Location	2 (Stroot as	nd Number or Ru	rai Pauta Numbar	
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Funers letely fille	edicai C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the b xaminer: On the bas and manne	is of examinat	wledge, tion and/	death occurred at for investigation, i	t the tin	ne, date and place pinion, death occu	, and due to the time	he cause(s ne, date an	and manner as d place, and due	stated. to the cause(s)	
To th	Me	29b. Signature and title of certifier	0			29c.	Licens	e number		29d. Da	ite signed (Month	Day, Year)	
. 3		* Kaman 1	1. Tul.			D	19	609		5.	16.06		
^		30. Name and address of person w	ho completed cause	of death (Item	1 23a) (T	ype, Print) R	9 <i>m</i>	DAN R	. Tu	LI	mi)		
1		30. Name and address of person w 10 8 10 DARNE	STOWN.	KOAS	) Sc	117E 20	2	GAITH	ERSIS	34124	mD2	0878	
Sta Regist		31. Date filed (Nichiti, Day, Fear)	1 8 2006	JISH AND SIVINA	(u) e								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year Lucile Vermillion Crowell РМ May 15, 2006 6:50 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Redding Ridge Drive Gaithersburg If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, March 3, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 232-58-9940 6. Sex . 19<u>12</u> 1 ☐ M 2 🛣 F 94 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2 XNo Gaithersburg Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20878 9 Redding Ridge Drive United States Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 K No Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed)

death with the Maryland or iteme 23s or 28s-f show 

Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

Director

Funerai

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ted

**Funeral** 

Director

**Physician** /Medica Examine

ed by the attending physicien and deteched for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed cete has been sign, page 2 should be within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director.

Division of Vital Records, P.O. Box 68760,

효	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retir	ed)			
Compl	12		Seamstress		Clo	thing	
Bec	17. Father's Name (First, Middle, Last)			18. Mother's Name (First,	Middle, Maiden	Sumame)	
To B	Walter King Vermi	.11ion		Nellie Mae	Burton		
5 3	19a. Informant's Name/Relationship (7)	ype, Print)	19b. Mailing Address (Street	at and Number or Rural Rout	e Number, City or	Town, State, Z	ip Code)
	Diana C. Tibbs/ D	aughter	9 Redding Ri	dge Drive, Ga	ithersbu	rg. MD	20878
	20a. Method of Disposition	20b. Pt	lace of Disposition (Name of	Date		cation - City or	
1 3	1 Burial 2 Cremation 3	Hemoval from State   M	emetery, crematory`or other pi etropolitan	1100	Alex	xandria	, Virginia
	4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service License	1	Crematory	2006 ress of Facility DeVol			
Ι.	21. Signature of Fulleral Service Chair.			eer Park Driv			
	MAN	Un				erspurg	
	23a. Part 1. Enter the disease, or composition of composition of the control of t	ilications that caused the death one cause on each line.	f. Do not enter the mode of dy	ring, such as cardiac or respi	ratory arrest,		Approximate Interval Between Onset and Death
ŀ	Immediate Cause (Final disease or condition		Heart Failure				Onset and Death
	resulting in death)	Due to (or as a consequ					
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Physician/Medical Examiner	IF FEMALE:						
an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnated 1 ☐ Live birth 2 ☐ Fetal		су	2	3d. Date of deli Month	very Day Year
Sici	1 □ Yes 2 🖾 No	4☐Pregnant at time of de 9☐Unknown	eath 5 Other (specify)				,
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Ž	Part II. Other significant conditions co	ontributing to death but not resu	ulting in the underlying cause of	iven in Part I. 23	3e. Did tobacco u	se contribute to	the cause of death?
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e				24	ta. Was an	24b. Were au	topsy findings available completion of cause of
E					autopsy performed?	death?	
ပိ			···		Yes 2 No	1 🗆 Yes	2 No
Be	25. Was case referred to medical examiner?	Hemital	10	26. Place of Death (Che			
2	I THIS ZESTNO			ther: 4 Nursing Home 5			cify)
ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. In Injury W	ury at 28d. D ork?	escribe how injury	occurred	
atic	2 ☐ Accident investigation		M 1	Tes 2 No			
€	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, factory, offic	9 28f. Lo	cation (Street and ty or Town, State)	d Number or Ru	ral Route Number,
ert	Tomodo	building, etc. (Specif)	// 		,,,,,		
Medicai Certification; To		ysician: To the best of my kno					
dic	(Check only 2 Medical Examone)	niner: On the basis of examinat and manner stated.	tion and/or investigation, in my	opinion, death occurred at t	he time, date and	place, and due	to the cause(s)
Me	29b. Signature and title of certifier		29c. Lice	nse number	29d. Date	signed (Monti	n, Day, Year)
	001	2001	D2	1334	May	16, 20	06
	91/1	Yoll				_	
1 0	30. Name and address of person who	death (Item		. #105	01		00000
	Daniel J. Goldber			prive, #125,	Olney, M	aryland	20832
ate	31. Date filed (Month, Day, Year)	32. Jegistrar's Signa	ture factle				
rar	MAY 18 2	2006 Brown 1	C. Manual				

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 7:13 P **Physician** 15, 2006 May Raymond E. Campbell /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bethesda Montgomery Suburban Hospital If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 2/5/18 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☑ M 2 □ F Washington, DC 577-09-2556 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ii Hygiane. Jother than "natural", or itema 23e or 28e-f show vent, the Madical Examinat De notified at 1 ☐ Yes 2 X No Oxon Hill Maryland Prince George Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20745 USA 6705 Livingston Road by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race · American Indian. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 ♥ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) D.C. Gov't Maintenance Engineer 12th 18. Mother's Name (First, Middle, Maiden Surname) other traumatic event, 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill ment of Health and Mental H sant: If item 27 is marked oil Catherine G. Lacey Raymond J. Campbell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8848 Woodlawn Way Springfield, VA. 22153 Richard E. Thompson/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Department of Important: If any injury or once. Wash. Nat'l Cemetery 5/22/06 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signature Funeral Service Licensee ales 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multiple Cerebral Infanct 5 YEARS **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physicien and for use es the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the aid be detached f Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4x ☑ Unknown icate has been sig , page 2 should b Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2X No certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1X Yes 2 No 2 ER/Outpatient 3 □ DOA this After this funeral of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: / 3 ☐ Suicide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) filled in by 4 | Homicide To the Hospital c within 24 hours af To the Funeral D completely filled is 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0009317 5/18/06 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) 2333 S NASH ST ARLENGTON, VA 22202 YRNE M.O. Kobert 2. Registrar's Signature 31. Date liled (Month, Day, Year) State Registrar 9 2006

			For State Registrar	State of	Maryland		artment of H tificate of L		ınd M	ental l		ene 0	06	17587
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	Examin	er	4a. Fecility Name (If not institution, gi The Hermitage at	St. JOhr	ns Creel	k	4b. City, Town, or Solomons	Cocation o	Deali			Calv	vert	
	Funeral Director		0. 000.00	Sex 1 □ M 2 🕱 F	7. Age (In yrs. la <b>84</b>	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of (Month)	Birth Day, Y	(ear) 21	Coul	place (State or Foreign ntry) rland
	pu »		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
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	th with 23a o	a D	962 Golden Wes	t Way			20657				τ	Jnited	Stat	ces
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other then "natural", or Items 23e or 28e-f show spiring or other traumatic event, Ire Medical Expiring most be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Moritage 4 Divorced	12. Was Dece Armed For 1  Yes If Yes, Give Year or Da	2 <b>∏X</b> √o		Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 <sup>K</sup> No	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	cify Yes o Rican, etc.	r No-	Blac	e - Americk, White, white,	
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anc	d be f	To Be	Thomas Whitting					Flora					,	
Maryland	shoul and Me s mark umati	F	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street a	and Numbe	or or Rura	i Route No	ımber, (	City or Town,	State, Zij	Code)
	and 2 salth a n 27 is		Beverly Parr- Da	ughter			Golden Wes				-			
Baltimore,	Pages 1 nent of He int: If Iter iry or oth		20a. Method of Disposition  1		JIAIO		sition (Name of matory or other place ction Ceme	· LICEV		2006		c. Location - Linton		
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) # <sub>3</sub>			23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that ca y one cause on ea	aused the death ach line.		er the mode of dying	g, such as	cardiac c					Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a <i>C</i>	Ipper	51	BI	le ed						Onsot and Death
	/Medical Examiner		1	Due to (	or ås a consequ	uence of):								
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ds, P.O	requires that the de een signed by the a nould be detached f	Completed by Ph	Part II. Other significant conditions	contributing to de	eath but not resu	ulting in the u	nderlying cause give	en in Part I.			Did toba			he cause of death?
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Re	The law	omi								1 O Y	autopsy performe es 2	ed?	prior to co death? 1 □ Yes	ompletion of cause of 2 No
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O	ding th. After funer	tlon	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigati		of Injury h, Day Year)	injury	Worl	k? Yes 2 ∐ !				inquity occur		
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	K		30. Name and address of person wh				Print)							
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	/Medic	al -	WILLIAM LA				·	4b. City, Town, o	Looption	of Dooth	MAY		006 c. County of Dea	9:0	00 A M
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	Funeral		5. Social Security Number	6. Sex		7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under		8. Date of (Month,	Birth Day, Year	MONTGO	thplace (Sta	ate or Foreign
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	ith the		10e. Street and Number 118 ROLLING	DOVD				10f. Zip Code				10g. C	itizen of What C	ountry?	
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ō	Phys or this oral di	o T	1 ☐ Yes 2 No 27. Manner of Death		28a. Date	of Injury	28b. Time of	of 28c. Inju	ıry at				6 ☐Other (Sp ury occurred	ecity)	
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Division	na Hospital or Attandi n 24 hours after death. ne Funeral Diractor: A bletely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Co 4 ☐ Homicide det	ild not be ermined		e of Injury - At h ling, etc. (Spec		reet, factory, office				n (Street a Town, Sta	and Number or F te)	Rural Route	Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medi	al Examin	er: On the I			h occurred at the tovestigation, in my	opinion, dea			ne, date a	nd place, and du	e to the cau	
)	To the I within 2. To the I complet	2	29b. Signature and title of or	ntier	e	ece	E.	11000	0358	59			Y 22,		ar)
	5		30. Name and address of per- LESZEK KAI	ROWIE	C, M	D 501	N FRE		AVE.,	, GA	ITHEF	RSBUI	RG, MD		
	Sta Regist	ate rar	31. Date filed (Month, Day, You		06	Registrar's Sign	A A	bert							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Maryth23, Year 12:30 PM Physician Richard Fielding Dienelt 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4490 Willowtree Drive Middletown Frederick If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 X M 2 □ F Yrs. Director 176-05-7664 92 Usual Residence of Decedent death with the Maryland 10a. State ir than "natural", or Itema 23a or 28a-f show the Medical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 255No Director MD Frederick Middletown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4490 Willow Tree Drive 21769 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. a filed within 72 hours efter all Hygiane.

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To the Funerel Director: After this completely filled in by the funeral. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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		•	For State Registrar	State of Marylan			t of Hea e of De			giene Reg. No.	16	17590
	Physicia	an	Decedent's Name (First, Middle, Last)	D.1010737					2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	DOROTHY H.	DUNCAN		4b City	Tour or Lo	cation of Death	MAY	15 2 4c. County	006	4:30 P M
	Examin	er	4a. Facility Name (If not institution, give s LAUREL REGIONAL I				UREL	cation of Death				EORGE'S
1	Funeral Director		5. Social Security Number 6. Sex 579-32-3594	7. Age (In yrs. 93	last birthday) Yrs.	If Unde Months		Under 24 Hrs. lours Min.	8. Date of Bir (Month, Da	th y, Year) 20 1912	9. Birth Cou M	place (State or Foreign ntry) [aryland
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20	d within 72 hours after death with the Maryland jiene. r than "natural", or iteme 23a or 28a-f ahow tre Medical Examiner must be recitited at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	<ol> <li>Was Decedent Ever in U Armed Forces?</li> <li>1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:</li> </ol>	"	Vas Dece Yes, spe	cify Cuban, I	inic Origin? (Sp Mexican, Puerti Specify:	pecify Yes or No Rican, etc.)	Specify	k, White,	can Indian, etc. White
200	2 hour	ted t	15. Decedent's Educ	eation	16a. Deced	lent's Usu	al Occupatio	n		16b. Kind of B	usiness/Ir	ndustry
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Tary	permit. Pages 1 end 2 should bu Depertment of Heelth and Menta Important: if item 27 is marked any inlyry or other traumatic an	F	19a. Informant's Name/Relationship (Type Pamela Shirley /		19b. Mailin	g Addres	s (Street and	Number or Ru	ral Route Numb	er, City or Town, n, Mary	State, Zi,	0 Code) 21629
e,	1 end Heelth am 27 ther to		20a. Method of Disposition	20b. F	Place of Dispo	sition (Na	me of	!	Date	20c. Location		
בסה	A Super		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, cren Linc	natory or	other place)	ry 5/	19/06	Brenty	•	
saitimore,	pertme portar y inlyr		21. Signature of Funeral Service License			Name a	nd Address o	# Facility	Funera	1 Home		
מ	\$0E = 8		John fun		470	P. (	D. Bo	x 5038,	Layton	sville,	Md.	
			23a. Pay11. Enter the disease, or complishock, or heart failure. List only or	cations that caused the deat le cause on each line.	h. Do not ent	er the mo	de of dying, s	uch as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	VENTRICU		RHYT	HMIA					
	Examiner			ATHEROSO		C CA	RDIOVA	SCULAR	DISEASE			YEARS
	p #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec								
_	cate be executed physicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	uence of):							
8/60	e be e rsicien e buris	dicalE										
٥	rtificati ng phy as the	Jedic	IE FEMALE.									
ROX	death certifi e ettending   id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnature 1 ☐ Live birth 2 ☐ Feta	it death 3		pregnancy				te of deliventh	ery Day Year
o.	at the de by the e teched f	yslc	1 ☐ Yes 2 🗹 No 9 ☐ Unknown	4□Pregnant at time of c 9□Unknown	leath 5L	Other (s	pecify)					
<b>_</b>	es that I	by Ph	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	ndertying	cause given i	n Part J.	23e. Did	obacco use con	ribute to	the cause of death?
Vital Records,	The law requires that ste has been signed b page 2 should be dete		HYPERTENSION						10	Yes 2 □ No	3 ☐ Pro	bably 4 Dunknown
ecc	e law re has be je 2 she	Completed							24a. Was	psy	Were aut	opsy findings available ompletion of cause of
E E									1 Yes		death? 1 🗆 Yes	2 🗆 No
<u> </u>	Physicien: Th r this certificete ral director, pag	o Be	25. Was case referred to medical examiner?	lospital: 1   Inpatient 2	ER/Outpatier	nt 3 🗆 D	Othor		th (Check only	one) dence 6 □Oth	(C	4.)
o	는 는 등	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		28c. Injury at Work?			how injury occur		<u>''y)</u>
Sior		atlo	1 Natural 5 Pending 2 Accident Investigation	(Month, Buy rour)	Mildry	М		2 □ No				
Division of	i or Attanation after death Diractor:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str fy)	eet, facto	ry, office			Street and Numi wn, State)	er or Rui	al Route Number,
_	To the Hospital or within 24 hours after To the Funeral Dir. completely filled in I		(Check only 2 Medical Exami	sician: To the best of my kniner: On the basis of examina	owledge, deat	h occurre	d at the time, n, in my opin	date and place	, and due to the	cause(s) and m	anner as	stated. to the cause(s)
	To the P within 24 To the P complete	Medical	29b. Signature and title of gentifier	and manner stated.			c. License n		-	29d. Date signe		``
	F 3 F 8		) Jakel	$\setminus$		and the same of th	D 240			MAY 1		
	12		30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type,	Print)						
			EUGENIO MACHADO			EFIEI	D ROAI	, SILV	ER SPRI	NG, MD.	209	04
1	St Regist	ate rar	31. Date filed (Month, Day, Year)  MAY 18 20	32 Registrar's Sign	ature do	soft)						

			1 - For State Registrar	State of M	aryland	l / Depar <i>Certi</i>					ental Hy	giene Reg. Na	200	16	17591
# 5 #	Physici	an	Decedent's Name (First, Middle, La								2. Date of D Month	Da		Year	3. Time of Death
	/Medic Examin	al	Catherine Hest  4a. Facility Name (If not institution, gi	re street and number)			4b. City,	Town, or	Location	of Death	May	16 4c	. County o	006 f Death	11:50 a <sup>~</sup>
a d	Funeral		Lorien of Taneyt  5. Social Security Number 6.		je (În yrs. la		If Under		If Under		8. Date of B	irth	Car		place (State or Foreig
	Director		242-26-9877 Usuaf Residence of Decedent	1□M 2 <b>只</b> F	80	Vrc	Months	Days	Hours	Min.	(Month, D		1925	Cour	NC NC
anyland	show d at	_	10a. State 10b. County  MD Carrol	1	10c. City	Town or Loca								1	0d. Inside City Limits
the M	r 28a-f	recto	10e. Street and Number	.1		Taney	10f. Zip					10g. Cit	izen of W	hat Cour	1 ☐ Yes 2 🙀 No
th with	23a o	al D	3233A Harney Roa	ıd				217	87				US	A	
72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	d by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marned 3 ☐ XVidowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give Year or Dates:			s Deced es, spec		spanic Or n, Mexica Specify		cify Yes or N lican, etc.)	0-		, White,	ean Indian, etc. hite
d within 72 hours at	an "natu Medical	Completed	15. Decedent's E (Specify only highest gi		5+)	16a. Deceder (Give kii life. DC	nt's Usua nd of wor NOT us	il Occupa rk done d se retired,	ition Juring mos )	st of workin	g	16b. K	ind of Bus	iness/In	dustry
	lygiene her the		12		,		Home	make					Own I		
d 2 should be file	Mental H arked ot atic ever	To Be	17. Father's Name (First, Middle, Las Charles Cupp								(First, Middle Howar		Sumame	)	
d 2 sho	Ith and 27 is mu		19a. Informant's Name/Relationship  rodd Davis/son	(Type, Print)		19b. Mailing 4271					Route Numi <b>Taneyt</b>	-			Code) 787
0es 1 ar	nent of Hea ant: If item ary or othe		20a. Method of Disposition 1   Burial 2 □ Cremation 3	☐Removal from State	20b. Pla	ace of Disposit metery, crema			- 1		2006				own, State
permit. Pages 1 a	partmen portant: y injury ce.		4 □Donation 5 □Other (Spec 21. Signature of Funeral Service Lib		Mt.	Pleas				ity	and C	Ta	neyto	wn,	MD
8	Depa Impo any ii		23a anti. Eni ir the sease, or cor shock, or in the alture. List only	-		41:	2 Wa	run shin	gton	Road	West	nape mins	ter,	MD	21157
1	nysician Medical xaminer		shock, or in failure. List one shock, or in failure. List one Immediate Cause (Final disease or condition resulting in death)		asta	tic	Lu	n g	g, such as	ance	✓	arrest,		+	Approximate Interval Between Onset and Death
be executed	and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b											
. 0	, A	Ical	l	Due to (or as	a consequ	ence or):									
The law requires that the death certifical	ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3 ⊟E	ctopic pro						23d. Date Mont		ory Day Year
res that	signed b	ē	Part II. Other significant conditions	contributing to death b	out not resu	lting in the und	erlying ca	ause give	n in Part	i.					ne cause of death?
he law requires t	ies been si 2 should	Completed									24a. Wa		24b. W	ere auto	psy findings available
The											perf	ormed? 2 ☐ No	de	ath? Yes	
Physician: 1	s certii directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ ⊀0	Hospitaf:	ent 2 1 F	R/Outpatient	3 🗆 DO	Othe			Check only		€ □Othou	/Canada	al .
Attending Phy	h. After this tuneral di	tlon: T	27. Manner of Death  1 Matural 5 Pending 2 Accident Investigation	28a. Date of Inju (Month, Da	ıry	28b. Time of fnjury		Bc. Injury Work		2	Bd. Describe				//
		Certification:	3 Suicide 6 Could not determined	28e. Pface of fn	jury - At hor c. (Specify)	me, farm, stree	t, factory	, office		2	Bf. Location City or To	(Street and	d Number	r or Rura	l Route Number,
To the Hospital or	• Funer letely fill	Medical	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the best miner: On the basis of and manner st	ıt examınatı	vledge, death o on and/or inve	occurred stigation,	at the tim in my op	e, date ai inion, dea	nd place, as ath occurre	nd due to the	cause(s	and man place, ar	ner as st nd due to	tated. the cause(s)
Toth	within To th comp.	Me	29b. Signature and title of certifier	MO		· · · · · · · · · · · · · · · · · · ·	290	License	number	35		29d. Da	te signed	(Month,	Day, Year)
1	10		30. Name and address of person who							Wes.	tmini	e le	,LI	10 2	(157
	S 20 24 2	te	31. Date filed (Month, Day, Year)	32 Pegisti	> 7 rar's Signati	ones	The	nue			,,	>1721			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2006 **Physician** 15, May 11:04A M Dayo Daramola /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fort Washington Fort Washington Hospital Prince George 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/17/43 Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 ☐ F Director 230-04-5186 Nigeria Usual Residence of Decedent 10c. City, Town or Location r then "naturel", or Items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits Maryland Prince George Clinton 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11407 Accolade Court 20735 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Yes, Give Specify: 2 If Yes, Give Year or Dates: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nit. Pages 1 and 2 should be filed within artment of Health and Mental Hygiene orant: If item 27 is marked other then "Injury or other treumatic event, the Max Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer United Technology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Daramola Elizabeth Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sonia E. Daramola/Wife 11407 Accolade Ct. Clinton, MD. 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny Injury or Resurrection Cem. 5/18/06 Clinton, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Geo. Kalas Funeral Home 21. Signature of Funeral Service Licensee - Hale 6160 Oxon Hill Rd. Oxon Hill, MD. 20745 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Ke 5 /Medical Due to (or as a consequence of): Examiner 2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner the attending physician and ned for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ certificate has been significator, page 2 should be 5 prolas 1 Yes 2 No 3 Probably Dinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes or Attending Physician: funeral director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ۵ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1-Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by To the Hospital or Al within 24 hours after of To the Funerel Direc 4 | Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person tho completed cause of death (Item 23a) (Type, Print) 11701 Coungston Rel ND 31. Date filed (Month, Day, Year) State Registrar MAY 1 9 2006

		1	For State Registrar		State o	f Maryland		artment of I			ental H	ygier Reg. l	-7111	06	175	94
- 9	S. 4186	4	Decedent's Name (First, Mice	dle, Last)							2. Date of I		Day	Year	3. Time of	Death
	Physici	3	Yolanda	Μ.		DeMatteo					May	13.	2006 2006		2:45	рм
	/Medio		4a. Facility Name (If not institut	ion, give s	treet and nur	mber)		4b. City, Town,	or Location	of Death	TIO y		4c. County			
	EXAMIN	eı	Potomac Valle				na Ct.	. Rock	ville	•			Mont	gomer	^v	
	Fungual		5. Social Security Number	6. Sex		7. Age (In yrs. las		If Under 1 Year	If Under	24 Hrs.	8. Date of E	Birth		9. Birthp	place (State o	r Foreign
7,0	Funeral Director		126-07-0001	1 🗆	M 2 xF	87	Yrs.	Months Days	Hours	Min.	(Month, 1			Cour	ylvan:	ia
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	/lanc		10a. State 10b. Cour	ty		10c. City,	Town or L	ocation						1	0d. Inside Ci	•
	Man	to	California	San D	iego	Ca	rlsba	ad							1 🗋 Yes	2 XN0
	the 28a	Director	10e. Street and Number					10f. Zip Code				10g.	Citizen of \	What Cour	ntry?	
	ath with the Marylan 23a or 28a-f show		6965 EL Cam:	no R	eal. c	ni+0 107	, 41.	76 920	ากจ					USA		
	ne 2:	Funeral	11. Marital Status		2. Was Deci	edent Ever in U.S		Was Decedent of	Hispanic Or	rigin? (Spe	cify Yes or	No-		e - Americ		
	ter dea	F	1 X Never Married 2 ☐ M		Armed Fo	rces?		If Yes, specify Cul			Hican, etc.)			ck, White,		
36	Irs a	by	3 ☐ Widowed 4 ☐ Divord	ed	If Yes, Gir Year or D	ve ates:		1 ☐ Yes 2 ☐ No	Specify	7			Specify	White	)	
21215-0036	s within 72 hours after death with the Maryland Jiene. rthan "natural", or lleme 23a or 28a-f show the Madical Examilier: Just be notified at		15. Deced	ent's Educ	ation		16a. Dece	dent's Usual Occu	pation	- 4 - 4 4		16b	. Kind of B	usiness/In	dustry	
15	- 3	Completed	(Specify only hig Elementary/Secondary (0-12	T	College (	1-40(5+)	life.	kind of work done DO NOT use retire	ed)	SI OF WORK	ig	D	epartm	ent of		
12	within iene. than	E	Elementary/Secondary (0-12	,	1		Buo	dget Offi	cer				-		m/ 0.S.	т.
0	라 다 다		17. Father's Name (First, Midd	le, Last)						er's Name	(First, Midd	lle, Maio	den Suman	10)		
an	2 00	To Be	Daniel DeMat	ceo					Genev	rieve	Canno	ne				
2	2 should be and Mental is marked o	F	19a. Informant's Name/Relation	nship (Ty)	oe, Print)		19b. Mail	ing Address (Stree	at and Numb	er or Rura	l Route Nur	nber, Ci	ty or Town,	State, Zip	Code) MD	20906
Maryland		1					222									
di.	Health Health tam 27 other tr		Udine Mika/ S 20a Method of Disposition	iste	r	20b. Pla	ce of Disp	N. Leis osition (Name of	Chi-	orid	BIVG.	200	. Location -	City or To	own, Sthe	ing,
ō	Ses = 5	1 9	1 Burial 2 Crematic			State		matory or other pl		May	20,					
Baltimore,	permit. Pages 1 Department of H Important: If its any injury or ot pnce.		4 Donation 5 Other			ment G	-	Heaven Cen		20	106	Si	lver	Sprin	ig, Mai	cyland
3al	ermit epar npor ny in		21. Signature of Funeral Servi	ce License	9		F	cancis J.	. Coll	ins E						
"	20 5 e d		Tychaid	/ / c	00			00 Univer					er Sp	ring,		
			23a. Part1. Enter the disease shock, or heart failure. I	or compli ist only or	cations that one cause on o	caused the death. each line.	Do not er	nter the mode of dy	ring, such as	s cardiac o	r respiratory	arrest,			Approximate Interval Bet Onset and	.ween Death
	Physician		Immediate Cause (Final disease or condition		Dmoss	monia										
	/Medical		resulting in death)	-		(or as a conseque	ence of):								2 Weel	cs
	Examiner			Ш.,		ntia									Years	
	AL . 1	jer	Sequentially list conditions, if any, leading to immediate	"	Due to	(or as a conseque	ence of):									
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	exec n an	Exa	resulting in death) Last		Due to	(or as a conseque	ence of):									
8760,	iaw requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the buriat-transit	lical		•	1.											
89	phys s the	edic														
×	eath certific attending p	N.	IF FEMALE: 23b. Was decedent pregnant	2		rtcome of pregnan		_					23d. Da	te of deliv	ery	
Box	atter for t	Physician/M	in the past 12 months?	T.		birth 2 ☐ Fetal on nant at time of de		□Ectopic pregnan □ Other (specify)	су			_	Mo	onth	Day	Year
o.	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unkr			(-, ),								
0	res that the de igned by the a be detached f	유	Part II. Other significant cond	litions cor	ntributing to o	leath but not resul	ting in the	underlying cause of	iven in Part	1.	23e. D	id tobac	co use con	tribute to t	he cause of	death?
ds,	sign sign	by	•								1	☐ Yes	2 🛣 No	3 🗆 Prol	bably 4 🗍	Unknown
Records,	w requir been si should	Completed											Fau			
ec	e taw has b	ğ										itopsy		pnor to co	opsy findings impletion of a	available ause of
<b>E</b>	Thaga age	5										enformed s 2.⊑		death? 1 ☐ Yes	2□ No	
Vital	Physician: The this certificate ral director, pag	Be (	25. Was case referred to med examiner?	ical	20 (131)				26. Plac	e of Death	Check on	ly one/				
>	ysic is ce direc	10	1 ☐ Yes 2 ☐XNo	1	lospital: 1	Inpatient 2 🗆 E	R/Outpation	ent 3 DOA	other: 4₺0 N	Nursing Ho	me 5□R	esidenc	e 6 □Ot/	ner (Speci	fy)	
of			27. Manner of Death		28a. Date	of Injury oth, Day Year)	28b. Time Injury		ury at		28d. Descrit	e how	injury occur	red		
0	Attanding r death. ector: After oy the fune	atio	1 Accident Inv	aing estigation	(	,,	,,		Yes 2	] No						
Division	Atta r deg ecto by th	Ę		uld not be ermined		e of Injury - At hor		treet, factory, offic	8			n (Stree Town, S		ber or Rur	al Route Nun	nber,
ō	afte Dir d in I	Certification:	4 [] Nomicide		Dunc	ling, etc. (Specify,	,				ony or					
	spita nours ners		29a. Certifier 1 🔀 Certi	fying Phy	sician: To th	e best of my know	viedge, dea	ath occurred at the	time, date a	and place,	and due to t	he caus	e(s) and m	anner as :	stated.	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medi	cal Exami		basis of examinati nner stated.	on and/or	investigation, in my	opinion, de	ath occurr	ed at the tin	ne, date	and place,	and due t	the cause(	5)
	othio oth	Me	29b. Signature and title of cer	tifier				29c. Lice	nse number	,		29d.	Date signe	ed (Month,	Day, Year)	
			Dan O	1.0	Clean	200	h .M	7	038	326	2	I	May I	16,	2006	
	LD		20.1	~	malated as	an of death (tra-	220) /									
			30. Name and address of per A. Mendhira			2401 Rese			Suita	330	Rocker	;11.	и м п	2001	7	
	Victoria de la Pari		31. Date filed (Month, Day, Y	ar)					AT CE	330,	MOCKV	T T T 6	-, PID	2001		
4	Regis	tate trar	MAY		006	Hegistrar's Signat	G. A	porte								

		1	For State Registrar	State of M	larylan		artment o			Mental Hyg	giene Reg. No.	006	175	95
	Physici	an	1. Decedent's Name (First, Middle, Las Ida May Davis	51)						2. Date of Dea Month May	Day	Year 2006	3. Time of 6:00	Death a M
	/Medic Examin		4a. Facility Name (If not institution, give		7)		4b. City, Tow	n, or Loca stmin				cunty of Death		
×	Funeral Director		5. Social Security Number 216-24-3217 6. S			ast birthday) 7 Yrs.	If Under 1 Ye		nder 24 Hrs.	8. Date of Birth (Month, Day 03/20/	, Year)	9. Birthi Cou	olace (State ontry)	
	Maryland -f ahow		Usual Residence of Decedent  10a. State 10b. County  MD Carr	roll	10c. City	, Town or Lo West	cation minste	r					10d. Inside Ci	•
	with the	I Director	10e. Street and Number 2219 Gablehamme	er Road			10f. Zip Coo	2115	7		10g. Citize	n of What Cou USA	ntry?	
036	i within 72 hours after death with the Maryland liene. r than "natural", or Itama 23a or 28a-f ahow Ita Medical Exami, ar must be codified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1  Yes 2  If Yes, Give Year or Dates	;? <b>≹</b> No		Was Decedent If Yes, specify 0 1 ☐ Yes 2 ₩		c Origin? (S xican, Puer ecify:	pecify Yes or No- to Rican, etc.)		Race - Amen Black, White, pecify: W		
21215-0036	na na	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) Coltege (1-40)	r 5+)	(Give	dent's Usual Od kind of work di DO NOT use re Radio	one during etired)		rking		of Business/Ir	ŕ	
Maryland 2	be filed ital Hyg id othe avant,	To Be C	17. Father's Name (First, Middle, Last, Thomas Greenlee	a Asbury					Jospe:	me (First, Middle, hine Mar	garet	Crocke		
	od 2 :		19a. Informant's Name/Relationship ( L. Eileen Cutshav			2219	•	hamme		d Westm Date	inste		21157	
Baltimore,	Pages 1 avent of Heament: If item ury or other		20a. Method of Disposition  1 □Surial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specific	y)	e C	emetery, cie endale	natory or other  Cemete	rpiace) <b>r</b> y		22/2006	Flin	itstone,		
Balt	permit. Pages Depertment of Important: If i any injury or 2000.		21. Signature of Fundral Service Licer	aclan	4		404 De	catur	Stre	eral Hom	berla	A. nd, MD	21502	2
en.	Physician /Medical		23a. Parf 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that causone cause on each  a	UTE	RIN	ter the mode of	dying, suc	ch as cardia	c or respiratory ar	rest,		Approximat Interval Bet Onset and	ween Death
3760,	death certificate be executed to entending physician and to use as the burial-transit	licai Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	is a conseq	uanca Uf).								
P.O. Box 68	the death certificate to the attending physic ched for use as the the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 ☐ Feta at time of d	I death 3[	□Ectopic pregn □ Other (specif				23	d. Date of deliving	-	Year
	The law requires that the des ste has been signed by the a page 2 should be detached fo	ρ	Part II. Other significant conditions	contributing to death	but not res	sulting in the u	inderlying caus	e given in	Part I.	23e. Did t	× .	e contribute to No 3 ☐ Pro	the cause of d	
I Records,		Completed								24a. Was autop perfo 1 Yes		death?	opsy findings ompletion of a	available ause of
Vital	Physician: this certificant all director.	Be	25. Was case referred to medical examiner?	Hospital:		150/0		Othor		ath (Check only o			4.1	
Division of	ng Phy fter this ineral d	Certification: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigatic 3 Suicide 6 Could not be	28a. Date of Ir (Month, I	njury Day Year)	28b. Time of Injury	of 28c.	Injury at Work?	□ Nursing I	28d. Describe I	now injury			
Divi	pitel or At ours after o lerel Direc filled in by		4 Homicide determined	280. Place of	etc. (Specil	(y) 	reet, factory, of		ate and place	City or To	wn, State)			,
	To the Hospitel or Attendi withih 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	(Check only 2 Medical Example)  29b. Signature and title of certifier	miner: On the basis and manner	of examina stated.	ation and/or in	29c. L	my opinio	n, death occ		date and p	signed (Month	to the cause(s	;)
	5			iak. G				2316	000		05	[32/20	DOC_	
	HR		30. Name and address of person who	. GALVI-	VIV	MA S	1911 5	ove	R AV	eave c	uesn	MIUSTE	T, WA	ier).And
	St Regist	ate trar	31. Date filed (Month, Day, Year) MAY 2 9 200	6 Elem	strar's Sign	ture for	este.							

		For State Registrar	State of	f Maryland	-	artment of				ene g. No. 20	06	175	59
		1. Decedent's Name (First, Middle, Las	it)						ite of Death	n Day	Year	3. Time of	Death
Physici /Medio		FREDERICK		E	EYLER			MAX			006	8:30	A M
Examin		4a. Facility Name (If not institution, give	street and nur	nber)		4b. City, Town	, or Location	of Death		4c. Count	y of Death		
		4 Maryland	Ave.			Walk	ersvil.	le		Free	dericl	ζ	
Funeral		5. Social Security Number 6. S		7. Age (In yrs. las.	t birthday)	If Under 1 Ye Months Da	ar If Under	Min. (M	te of Birth	Yearl	9. Birthp	lace (State o	r Foreig
Director		217–28–5017	XM 2□ F	74	Yrs.	WIGHTIS	75 110013	Octob	er 22	2, 1931	Mar	yland	
0		Usuel Residence of Decedent											
how		10a. State 10b. County		10c. City, 1	Town or Lo	cation					1	0d. Inside Ci	-
hours after death with the Maryland turel, or items 23a or 28a-f ehow al Exeminer must be notified at	턍	Maryland Frederi	ck	Walk	ersvi	ille						1 ☐ Yes X	2 🗀 19
82.5	Directo	10e. Street and Number	-			10f. Zip Cod	9		10	g. Citizen of	What Coun	try?	
3a 6	O E	4 Maryland Ave.				2179	93			USA			
ms (	Funeral	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U.S.	13. 1			rigin? (Specify Y an, Puerto Rican,	es or No-	14. Ra	ce - Ameno		
1 1 1		1 Never Married 2 Married	1 TYes	2 X No		1 ⊡ Yes 2 🖾			, 610.)	1	whit∈		
	þ	3 Widowed 4 Divorced	If Yes, Giv Year or D	ates:		105 263	чо зреспу	·.		Speci	yviii cc	-	
a atra	Completed	15. Decedent's Ed	ducation		16a. Dece	dent's Usual Oc	cupation	st of working	1	16b. Kind of E	Business/Ind	dustry	
within 12 ene. then "nat	pie	Elementary/Secondary (0-12)	College (1	1-4or 5+)		kind of work do DO NOT use re							
E .	no:	10			Tru	ıck Driv	ver			Trucki	.ng		
is Hygiene in a transfer of the state of the	BeC	17. Father's Name (First, Middle, Last,					18. Moth	ner's Name (First	t, Middle, N	faiden Surna	me)		
	To	Roger Eyler					Erlin	ne Keene	y				
Du m		19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	ng Address (Str	et and Numb	oer or Rural Rout	te Number,	City or Town	, State, Zip	Code)	
Health and Men them 27 is marke other traumatic		Mary Elizabeth Ey	ler/Wif	e	4 Mar	yland a	lve., V	Valkersv	ille,	Mary1	and 2	1793	
it Hear	'	20a. Method of Disposition		20b. Plac	ce of Dispo	sition (Name o	olace)	Date	2	20c. Location	- City or To	wn, State	
rages nent of unt; if it ury or o		1 ☐ Burial 2 📉 💢 remation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the C		State		Cremato	1	May 23,	2006	Freder	ick	Marv1	and
트립트교		21 gnature of Fundal Service Live		- 4 - 4 - 4 - 4	22	2. Name and Ad	dress of Facil	lity Stauff	or Fu	nore1	Uomo c	D A	2110
		14	14		163	1 Open	umtour	Pike,	Erodo	merar	Morre 1	ond 2	170
_		23a. Party Enter the disease, occurs shock, of heart failure. List only	plications # at c	aused the death.	Do not ent	er the mode of	dying, such a	s cardiac or resp	iratory arre	est,	Maryi	Approximat	9
		shock, of heart failure. List only timmediate Cause (Final										Interval Bet Onset and I	
hysician /Medical		disease or condition resulting in death)	a MY	OCAK	DIA	-L 15	chev	nico				nou	2
Examiner			Due to	OCAR (or, as a consequent tastat	nce of):		201.00					10.00	+
	-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a conseque	nce of):	ung	ance	1	_			100	Out 1
De jist	n]u	cause. Enter Underlying Cause (Disease or injury		(		J							
te be executed ysician and te burial-transit	Examiner	that initiated events resulting in death) Last	c	(or as a conseque	nce of):								
ate be executed hysician and he burial-transit	cal E												
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death certifica e attending ph of for use as th	Physician/Med	IF FEMALE:	23c. If ves. ou	tcome of pregnanc	ev					23d D	ate of delive	arv.	
atten	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	ointh 2 Fetal di	eath 3	Ectopic pregna					onth	-	Year
the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkn			_ Out of (9,000m)	/						
that the death	4	Part II. Other significant conditions	contributing to d	eath but not resulti	ing in the u	nderlying cause	given in Part	1. 2	3e. Did tob	acco use cor	tribute to th	ne cause of o	leath?
signe	b		•		•	, ,			1 □ Ye	s 2 🗆 No	3 ☐ Prob	ably 4 □l	Jnknov
w requir been si should	stec												
The law requires that the ate has been signed by th page 2 should be detache	npl							2	4a. Was ar autops perforn	y . i	Were auto prior to cor death?	psy findings npletion of c	availab ause o
sicien: The law certificate has t rector, page 2 s	Completed							1	☐ Yes 2	No	1 Yes	2□ No	
ysicien: is certific director,	Be	25. Was case referred to medical examiner?						ce of Death (Che	ock only one	9)			
Z S D	2	1 ☐ Yes 2 ☑ No			R/Outpatie	IL SU DOA		lursing Home				y)	
D 0 0	Ë	27. Manner of Death 1 Natural 5 □ Pending	28a. Date (Mon	of Injury 2 hth, Day Year)	8b. Time o Injury		njury at Work?		Describe ho	w injury occu	rred		
ttending death. ctor: Ater y the fure	catt	2 Accident investigation				М	1 Yes 2						
ie de	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	289. Place	e of Injury - At hom ling, etc. (Specify)	e, farm, st	reet, factory, off	ce		ocation (Sti lity or Town	reet and Num i, State)	ber or Rura	I Route Num	ber.
rs af													
To the Hospital or attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai	(Check only 2 Medical Exa	hysician: To the trainer: On the b	e best of my knowl pasis of examinatio	ledge, deat in and/or in	h occurred at the	e time, date a ny opinion, de	and place, and de eath occurred at	ue to the ca the time, da	ause(s) and mate and place	nanner as st , and due to	tated. the cause(s	3)
To the Hospital or within 24 hours afte To the Funeral Direction Completely filled in	ed	one)	and man	ner stated.	• . "	1			-, -,	24.5	- 4 /44	Day 1/	
To To t	Σ	29b. Signature and title of certifier	-14-			29c. Lie	ense number	611	25	ed. Date sign	ea (Month,	uay, Year)	
_		DA-2. HEG	MAIM	V			441	04		8	-dd	-00	
10		30. Name and address of person who	completed cau	pasis of examination inner stated.  See of death (Item 2)  Agistrar's Signatu	(Type,	Print)	1000	1	V 2	1707	A	ZH	EG
1		46 B Thoma	S JOH	nson [	74 (M	6 +ve	W III	NI	1) 0	- 1702			
	ate	31. Date filed (Month, Day, Year) MAY 23	7006 32. F	gistrar's Signatu	2	hard .							
Regist	trar	(समा ६३	2000	TOWN A	- 1								

Amended Item 29c 05/19/2006 Carroll County, wj1
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical May lang MIVERSIM 5. Social Security Number/ 7. Age (In yrs. last birthday) If Under 24 Hrs 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Months 1**⊠**M 2□ F 87 Mary Tand 219-36-1671 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthen "neturel", or iteme 23e or 28e-f ehow the Madical Examinar must be notified at MD Carroll New Windsor 1X Yes 2 □ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 206 Church St. 21776 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after Titled Folces?

☐ Yes 2 🏲 No
f Yes, Give
Year or Dates: 1 Never Married 28 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry petroleum service/ Elementary/Secondary (0-12) College (1-4or 5+) Truck driver/police officer town government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental h Pages 1 and 2 should be Uriah S. Fritz Mary V. Fritz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Betty W. Fritz - wife 206 Church St., New Windsor, MD 21776 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State rtment of h rtant: if ite njury or ot t Burial 2 ☐ Cremation 3 ☐ Removal from State Department Important: i eny injury o St. Paul's Luth. Cem. 5/19/2006 4 ☐ Donation 5 ☐ Other (Specify) Uniontown, MD 21. Signature of Feneral Service ( 22. Name and Address of Facility Hartzler Funeral Home 310 Church St., New Windsor, MD 21776 23a. Part1. Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nultiple **Physician** complications MUVIES /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HO BY WEDLER EXMINER Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death signed by the a 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 PNo 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy perform 1 Yes 2 No 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: npatient Certification: To 2 ER/Outpatient 3 DOA After this 28d. Describe how injury occurred INVOCUED IN 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural Injury death 6152 P 1 ☐ Yes 2 No 25/2006 nours after death neral Director: / filled in by the f 2 Accident COLLISION 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ROAD RT 31 @ OLD NEW WINDSOR PIKE, NEW WINDSIR within 24 hours a

To the Funeral I

completely filled To the Hospitel 70 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) <del>36</del>-P19776 ddress of person who completed cause of death (Item 23a) (Type, Print) 4 Nau 10th/1ng 22 S. Greene St. Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Segistrar's Signature State

Registrar

19

2006

		1_ Stete	epartment of Health and No		0000	17500						
Physicia	an	Registrar      Decedent's Name (First, Middle, Last)  JOSEPH JAMES FISHER	oranio or Douir	2. Date of Death MAY 19 Da	ay 2006	3. Time of Death 6:09 PM						
/Medic Examin		4a. Facility Name (If not institution, give street and number) SUNRISE ASSISTED LIVING	4b. City, Town, or Location of Death ROCKVILLE	40	County of Death							
Funeral Director		5. Social Security Number 6. Sex 188 – 14 – 1335 6. Sex 2 F 82 Yrs	Months Days Hours Min.	8. Date of Birth (Month, Day, Year, OCT 27 1		ace (State or Foreign try) PA						
Maryland f ehow	ō	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town o   MD   MONTGOMERY   PC	r Location		10	od. Inside City Limits						
vith the Maryla or 28a-f ehov	Director	10e. Street and Number	10f. Zip Code	10g. Ci	itizen of What Count	try?						
2 should be filed within 72 hours after death with the Maryland and Menial Hygens.  ie markad other than "natural; or iteme 23a or 28a-f ehow aumatic event, the Madical Examiner must be notified at	by Funeral	17300 CHISWELL RD.  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  17300 CHISWELL RD.  12. Was Decedent Ever in U.S. Armed Forces?  174 Yes 2 No 1941 - If Yes, Give Year or Dates: 1946	20837  13. Was Decedent of Hispanic Origin? (Spit Yes, specify Cuban, Mexican, Puerto  1 Yes 2 No Specify:	ecify Yes or No-	SA  14. Race - America Black, White, e  Specify: WHI	etc.						
s 1 and 2 should be filed within 72 hours I Health and Mental Hygiene. Item 27 ie markad other than "natural; other traumatic evant, the Madical Exe	Completed I	(Specify only highest grade completed)  [Secondary (0-12)   College (1-4or 5+)	ecedent's Usual Occupation Sive kind of work done during most of work fe. DO NOT use retired) ECTRONICS ENGINER	Ing NA	Kind of Business/Ind VAL AIR MMAND	ustry						
uld be filed Aental Hygi rkad other tic evant, t	To Be Co	17. Father's Name (First, Middle, Last) WILLIAM FISHER	18. Mother's Name	e (First, Middle, Maider	n Sumame)							
and 2 shouealth and he 27 ie ma		CATHERINE OUELLETTE/DAUGHTER 1		POOLE	SVILLE,	MD 20837						
permit. Pages 1 and 2 Department of Health a important: if item 27 is any injury or other trac		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  ARLING	isposition (Name of crematory or other place)  GTON NATIONAL	0/06 ARL	ocation - City or Tov INGTON,							
permit Depar impor any in		21. Signature of Funeral Service Licensee	22. Name and Address of Facility HILTON FUNERAL F P.O. BOX 86, BAF		, MD 20	0838 Approximate						
Dhysician hysician and physician and physician and physician and the prival-transit	ai Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  WELL DIFFERENTIATED SQUAMOUS CELL CARCINOMA Due to (or as a consequence of):										
ath certific	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknow	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery Month Day Year								
quires thet the de n signed by tha e uld be detached t	by	Part II. Dther significent conditions contributing to death but not resulting in th INSULIN DEPENDENT DM	ne underlying cause given in Part I.	23e. Did tobacco	use contribute to the							
The law require ate has been si page 2 should I	Completed			24a. Was an autopsy performed?	prior to com death?	sy findings available apletion of cause of						
ysiclan: is certific director,	To Be (	25. Was case referred to medical examiner?  1  Yes	Othor	h (Check only one)	6 □Other (Specify	)						
To the Hospitel or Attending Physician: The law within 24 hours eiter death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2		27. Manner of Death 1. Natural 5 Pending (Month, Day Year) Inju 2 Accident investigation	ne of 28c. Injury at	28d. Describe how inju	ury occurred							
To the Hospitel or Attendi within 24 hours efter death. To the Funerei Diractor: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)		City or Town, Stat								
the Hosp in 24 hou the Fune	ledical	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, of the desired physicien of the desir	or investigation, in my opinion, death occuri	red at the time, date an	nd place, and due to	the cause(s)						
ot viting	Σ	Description → Shama R. Mittalmy	29c. License number 2006/38		ate signed (Month, $C$	Oay, Year)						
5			cians La., #152,	ROCKVILL	E, MD							
Sta Registr		31. Date filed (Month, Day, Year) 32. Reg strar's Signature	Spark									

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

		1 - For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of F		, ,	iene g. No.	006	17599
Physici		Decedent's Name (First, Middle, Last	FRIDLEY				2. Date of Deat Month MAY	Day	Year 2006	3. Time of Death 2:45 P. M
/Medio Examin		CONRAD DALE  4a. Facility Name (If not institution, give  14408 UHL HIGHW	street and number)		4b. City, Town, o	r Location of Dear		4c. Cou	inty of Death	
Funeral Director		5. Social Security Number 6. S		(In yrs. last birthday)				Year)	Coun	olace (State or Foreign htry) VIRGINIA
Maryland f show	tor	10a. State 10b. County MD ALLEG.		10c. City, Town or Lo					1	0d. Inside City Limits 1 ☐ Yes 🌠 No
with the M 3a or 28e-f 1 be notifie	i Director	10e. Street and Number 14408 UHL HIGHW	AY, S.E.		10f. Zip Code 21502		1	0g. Citizen	of What Coun	itry?
72 hours after death with the Maryland 72 hours after death with the Maryland insturel; or Items 23s or 28s-f show digal Examinat must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		Race - Americ Black, White, ecify: WHIT	etc.
.= .	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occup o kind of work done DO NOT use retired	durina most of wo	prking		Business/Ind	dustry
2 should be filed with and Mental Hygiene. Is marked other ther eumatic event, Item	To Be C	17. Father's Name (First, Middle, Last)  CONRAD CODY F	<del>-</del>			NELLI		Maiden Sun JSTICI	name)	
and 2 sho ealth and m 27 is m		19a. Informant's Name/Relationship (SHADA FRIDLEY / G		ER 203	34 FIRETO		ural Route Number.  JAMSVI			4
permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other tree		20a. Method of Disposition 1 ☐ Burial 2 ② Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			osition (Name of matory or other plac VD CREMAT	1			on - City or To IBERLAN	
permit. DepartmImporte any inju		21. Signature of Funeral Service Licen	Lear heen	(2)			HOME, P.		. MD 2	21502
Physician /Medical		23a. Part1. Enter the pisease, or composhock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	one cause on each line	OBSTRUCTIV	ter the mode of dyin	g, such as cardia	c or respiratory arre			Approximate Interval Between Onset and Death YEARS
eate be executed thy sician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to inmisciate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Doe to for as a	consequence of):  consequence of):						
The law requires that the death certifical the has been signed by the attending phage 2 should be detached for use as the	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy				Date of delive Month	ory Day Year
quires that on signed b	by P	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	inderlying cause giv	en in Part I.	23e. Did tob	_		ne cause of death? ably 4 Unknown
	Completed					·	24a. Was ar autops perform 1 □ Yes	v	b. Were autor prior to con death? 1 \( \text{Yes}	psy findings available npletion of cause of 2 No
Physicien: The I rthis certificate ha	To Be	25. Was case referred to medical examiner?  Days 2 No	Hospital: 1  Inpatient	t 2 🗆 EP/Outpatier	nt 3 DOA Oth		ath (Check only one		Other (Specify	·)
fe fe		27. Magner of Death  Natural 5 Pending 2 Accident investigation		Year) 28b. Time o	Wor	y at k? Yes 2 □ No	28d. Describe ho	w injury oc	curred	
Tor A after Direction by	Certification:	3 Surcide 6 Could not be determined	28e. Place of Injur building, etc.	y · At home, farm, sti (Specify)	reet, factory, office		28f. Location (Str City or Town		mber or Rural	Route Number,
To the Hospitel within 24 hours a To the Funerel I completely filled	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysicien: To the best of niner: On the basis of a and manner state	examination and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occi	e, and due to the ca urred at the time, da	use(s) and ite and plac	manner as sta ce, and due to	ated. the cause(s)
To the within Complex	Σ	29b. Signature and title of dertifier			29c. Licenson		29	_	ned (Month, L	
n w		30. Name and address of person who Paul Snow, M.D	124 W. TH	IRD STREE		LAND, MD	21502			
Sta	ate	31. Date filed (Month, Day, Year)	NNS 32. R Sistrar	's Signature	book					

		1	For State Registrar amend #8&9 PER FH G856 6/22 FGR	<b>ezty/องเลเ</b> ป-lealth and N ctif <del>ig</del> ate of Death	Mental Hygiene	06 17601
H	Physicia		1. Decedent's Name (First, Middle, Last)  James Elmer Forbes, Sr.	, G11	2. Date of Death Month Day MAY 25TH, 20	year 06 17:55 M
E	/Medic Examin	_	la. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. Count	y of Death
	Funeral		MEMORIAL HOSPITAL  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  1 N M 2 □ F  65  Yrs.	CUMBERLAND  If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
	Director	-	218-36-2482  Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or L	ocation	9 <del>-9-</del> 1940 23	Virginia  10d. Inside City Limits
	e Maryla Ra-f shov		PA Somerset Fairhope			1 🛣 Yes 2 🗌 No
	th with th	Funeral Director	10e. Street and Number 120 Comps Road	101. Zip Code 15538	USA	What Country?
036	within 72 hours after death with the Maryland she. Then "netural, or items 23e or 28e-f show the Modical Examiner must be notified at	þ	11. Marital Status  1 Never Married 2 Narried  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	pecify Yes or No- p Rican, etc.) 14. Ra Bla Specia	ce-American Indian, ack, White, etc. <sup>fy:</sup> White
Maryland 21215-0036	s 1 and 2 should be filled within 72 hours after death with the Marylan if Health and Mental Hygiene a fathow them 23s or 28s-f show tem 21 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation a kind of work done during most of work DO NOT use retired) CR Driver	king	Business/Industry uckina
and 7	ould be filed whental Hygis Aerked other istic event, It	To Be C	17. Father's Name (First, Middle, Last)  Elmer Forbes Sr.	18. Mother's Nam	ne (First, Middle, Malden Suma 2ll McNeil	me)
Mary	and 2 should be ealth and Mental n 27 is marked on traumatic ev		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Ru Rustic Dr., Ship)	ral Route Number, City or Town	
ഖ്			20a. Method of Disposition 20b. Place of Dis	osition (Name of ematory or other place)  Wn Gematory 5-2	Date 20c. Location	- City or Town, State
Baltir	permit. Page Department of Important: If any injury of anca.		21. Signature of Funeral Service Licensee	wey H. Zeigler 20 Box 636 Hyna	. Funeral Home	
di T	Pnysician	8 4	23a. Part 1. Inter the disease of complications that caused the death. Do not enshock for heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a.	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):  Sequentiatly list conditions,  b.	0 8		
o,	cate be executed physicien and the burial-transit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):			1
. Box 68760	ath certifi attending for use as	Physician/Medical		□Ectopic pregnancy		ate of delivery lonth Day Year
ds, P.O.	uires that the de signed by the a d be detached	5	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use coi	ntribute to the cause of death?  3 □ Probably 4 □ Unknown
Vital Records,		Completed			24a. Was an 24b autopsy performed? 1 Yes 2 No	. Were autopsy findings available prior to completion of cause of death?  1  Yes 2  No
Vita	Physician: Th rthis certificete ral director, pag	To Be (	25. Was case referred to medical examiner?  1  Yes  No  Hospital: 1 Inpatient 2  ER/Outpatient	Other	th (Check only one) ome 5 Residence 6 O	ther (Specify)
Division of	ling Afte fune	Certification: T	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident Investigation  3 Suicide 6 Could not be	Work? M 1 □ Yes 2 □ No	28d. Describe how injury occu	
Divi	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the i	Certif	4 Homicide determined 288. Place of injury - At nome, farm, so building, etc. (Specify)		28f. Location (Street and Num City or Town, State)	
	the Hoap nin 24 ho the Fune npletely f	ledical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occu	rred at the time, date and place	
	5	Σ	29b. Signature and title of certifier	29c. License number D33280		26, 200 C
,	nes		30. Name and address of person who completed cause of death (Item 23a) (Type GUPTA, SUNIL K., M.D., 625 KENT AVEN		•	
	St Regist	ate rar	31. Date filed (Month, Day, Year)  MAY 2 6 2006  32 Registrar's Signature	barle		

State of Maryland / Department of Health and Mental Hygiene

				tate of twe	ii yiaiia	Certific				Reg. No.	006	17602
	Physician	1. Decedent's Name (First, M.	_	•					2. Date of D Month	Day	Year	3. Time of Death
	/Medica	Vauda Ma		Grace et and number)				4b. City, Town, or	May Location of Dea	26 th 4c. C	2006 county of Deat	6:30 P.M.
B.A. spi	Examine	Devlin Manor			enter	_		Cumber	land	A	11egan	v
	Funeral	Social Security Number	6. Sex	7. Age	(In yrs. las		nder 1 Year	If Under 24 Hrs	s. 8. Date of B	irth	9. Biri	tholace (State or Foreign
	Director	234-70-1505	1 □ M	2 <b>IO</b> F	87	7 Yrs.	ths Days	Hours Will	8. Date of Bi (Month, D Sept. 18	,1918	M	Dintry)
7	and w	Usual Residence of Deceden  10a. State 10b. Cou			10c. City,	Town or Location						10d. Inside City Limits
7	Mary	g wv	Hampsh	iro			Sprin	gfield				1 ☐ Yes 🛣 No
,	or 28e-fall	10e. Street end Number	пашрыт	ILC			Zip Code	<u>sileiu</u>		10g. Citize	on of What Co	ountry?
	23 c 23 c	P.O. Box 144	<u>'</u>					26763		U	SA	
1	r itema 23e	11. Marital Status	12.1	Was Decedent E Armed Forces?	ver in U,S.	13. Was De	ecedent of I	Hispanic Origin? (	Specify Yes or N rto Rican, etc.)	0- 14	I. Race - Ame Black, Whit	
გ <sup>ქ</sup>		1 □ Never Married 2 □ I 3 □ XWidowed 4 □ Divol	Married	1 ☐ Yes <b>②KX</b> N If Yes, Give	lo		s <b>2/21/</b> No					ite
8	tural'		dent's Education	Year or Dates:	.	16a. Decedent's l	Jsual Occur	pation		16b. Kind	d of Business	
15	in /2	15. Dece (Specify only hi Elementary/Secondary (0-1	ghest grede co	mpleted) College (1-4or 5		(Give kind of life. DO NO	work done Tuse retire	during most of wo d)	orking			,
213	m = 1 mm	Elementary/Secondary (0-1	(2)	College (1-401 5	-/	Homem	aker			Н	ouseke	eping
פַ וּ	tal Hygie d other event, II		dle, Last)					18. Mother's Na	ame (First, Middle			
yla	Men atic	William Pres	ston Go	od					e Grands			
ਲ ਾ	is mark is mark raum	19a. Informant's Name/Relat				19b. Mailing Add						Zip Code)
Θ.	s 1 and f Health item 27 other t	Richard L. G	race	(son)	20b Plac	P.O. Bo	X 144 Name of	Spring	tield, V	N 26/	63 ation - City or	Town State
Baltimore,	i i i	1 Ma Burial 2 ☐ Cremati		oval from State	cerr	netery, crematory	or other pla	·	5/30	7.50		
₽ ;	교론관금 .	4 ☐ Donation 5 ☐ Othe 21. Signature of Funeral Sen			Spri	ngfield (	Ceneto e and Addre	an of Facility		_	gfield	-
Ba	Depa Impo eny l			12				M				lamp. LLC
		23a. Part1. Effer the disease shock, of heart failure.	o, or complication	ons that calised	the death.	Do not enter the i	mode of dyi	ch Lane	ac or respiratory	arrest,	וכוט	Approximate
F	Physician	shock, of heart failure.	List only one ca	ause on each lin	Θ.						i	Interval Between Onset and Death
7	/Medical	Immediate Cause (Final disease or condition			(3)	cute 1.	2	Factor	•		1	y don
	Examiner	resulting in death)	a			s e consequence		y				
	executed in and ial-transit		b		Detu	deston						10 day
710	and and I-train	Sequentially list conditions,			Due to (or a	s a consequence	of):				1	
68760,	be eg	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	Ref	me	to Iren	mu	enter			ĺ	2 whe
. Box 68760,	g physician anu as the burial-tr nsit	resulting in death) Last	1	, (	Due to (or a	s a consequence	of):				1	
Вох	out the death centing by the attending letached for use a Dhyeician/M		d									
<b>m</b>	death deathe	Part II. Other significent con	ditions contribu	uting to death bu	t not resulti	ng in the underlyi	ng cause gi	ven in Part I.	23b. Did	tobacco u	se contribute	to the cause of deeth?
0	law requires that the de as been signed by the a selection of the contraction or the contraction of the cont								1□	Yes 2	-No 3□Pi	robably 4 Unknown
	igned bed	3									Fin	
of Vital Records,	Ine law requires the law been so that has been so that have been so that had been so that h									s an autops ormed?	' H	Were autopsy findings available prior to completion of cause
Sec.	has b								1 00000			of death?
a E	cate ha									Y56 3H	No	1 ☐ Yes 2 ☐ No
<b>=</b>	r this certificate aral director, pag		dical Hosp	oital:			Ott		eath (Check only			
ō	rthis eral di		2	1 ⊔ Inpatie 8a. Date of Injur	y 2	Bb. Time of	DOA 28c. Inju Wo	ner: 4⊟ Nursing ny at	Home 5 ☐ Res 28d. Describe			uny)
o F	th. : Afte	1 □ Natural 5 □ Pe 2 □ Accident inv	nding estigation	(Month, Day	Year)	Injury M		rk?  Yes 2□No				
Division	ar dea ector by th	3 ☐ Suicide 6 ☐ Co	uld not be termined 2	8e. Place of Inju		e, farm, street, fac	ctory, office			(Street and own, State)	Number or Ru	ural Route Number,
בֿ	rs after death.  al Director: After ted in by the funers	5		bonding, etc	. (opadity)				3.1, 0. 10	,)		
1	within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director.  Madical Certification: To	29a. Certifier 1☐ Certifier 1☐ Certifier 2☐ Medi		On the basis of	examination	edge, death occur n and/or investiga						
4	thin 2 the F mplet	one) 29b. Signature and title of cer	tifier	and manner sta	ted.		29c. Licens	se number		29d. Date	signed (Mont	th, Day, Yeer)
F	- ¥ - 8		llen :	20				00175	65	489	my 28,	
	n	30. Name and address of per			ath /ltom 0	3a) (Type Briet)						
	V											
		1- JBsiliv	11 ()	922	N ST	"I Hay	62	Uzle	177	2150	2	

DHMH 16 Rev 6/95

		For State Registrar	State of Mary		artment of H			ene g. No.O O O C	13600
Physici	an	Decedent's Name (First, Middle, Last,					2. Date of Death Month	7 1 1 1 1 1 1	3. Time of Death
/Medic Examir	al	Robert 4a. Facility Name (If not institution, give	Richar street and number)	<u>d</u>	Gormen 4b. City, Town, or	Location of Deat	MAY	22 2006 4c. County of Deat	
Funeral		MEMORIAL HOSPITAL 5. Social Security Number 6. Se		yrs. last birthday)	CUMBERI If Under 1 Year Months Days			ALLEGANY 9. Birt	hplace (State or Foreign
Director		220-16-6895 Usual Residence of Decedent	M 2□F 82	Yrs.			04/27/1	0 0 1	land
Maryian f show	jo	MD Alles		c. City, Town or Lo (	cation Cumberlan	d			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
vith the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
be filed within 72 hours after death with the Maryland half Hygjene. Ad other than "natural", or Iteme 23a or 28a-f show event, the Medical Examinar must be motified.	by Funerai	P.O. Box 76 (SI  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ∑Yes 2 ☐ No1 If Yes, Give	943 <b>-</b>	2150 Was Decedent of H If Yes, specify Cuba 1 □ Yes 2∑No		Specify Yes or No- to Rican, etc.)	USA  14. Race - Ame Black, Whit	e, etc.
thin 72 hours le. lan "natural" lMedical Ex	Completed b	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0·12)		16a. Dece	dent's Usual Occup kind of work done of DO NOT use retired	during most of wo	rking 1	6b. Kind of Business/	Vhite Undustry
e filed al Hygid f other vent, it	Be	12 17. Father's Name (First, Middle, Last) Samuel	Isaac	Gorn	Firefigh		me (First, Middle, M		ipal Ller
2 should be and Mental is marked c	2	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Maili	ng Address (Street	and Number or R		City or Town, State, 2	Zip Code)
ages 1 and 2 should b nt of Health and Ment t: If Item 27 is marked y or other traumatic e		Anne F. Gormer / 120a. Method of Disposition  1 Burial 2 Micremation 3 F  4 Donation 5 Other (Specify)	Removal from State	Ob. Place of Dispo cemetery, crei		(e)		Cumberland	
permit. Pages 'Department of himportent: If ite any injury or ot one.		21. Signature of Fulleral Service Licens		22	2. Name and Addres	ss of Facility A		ly Funeral	Home, P.A 21502
death certificate be executed  (Washington and washington and for use es the burial-transit	dical Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ASPIRATIO  Due to (or as a co  d.	onsequence of): ഗര്ജ്യാലാര് ഗ്രീ:	NIA				Interval Batween Onset and Death  WEEK
that the death certific ed by the attending p detached for use es!	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	⊒Ectopic pregnancy □ Other (specify)			23d. Date of del Month	ivery Day Year
w requires that the been signed by th should be detache	þ	Part II. Other significant conditions co	•	ot resulting in the u	nderlying cause giv	en in Part I.		acco use contribute to s 2 🔯 No 3 □ Pr	the cause of death?
The law ate has b page 2 sl	Completed						24a Was an autopsy perform 1 □ Yes 2	prior to	itopsy findings available completion of cause of 2 \( \text{No} \)
ysicia s cer direct	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 XInpatient	2 ER/Outpatier	nt 3 DOA Oth	0.0	ath <i>(Check only one</i> Home 5 ☐ Resider	nce 6 □Other <i>(Spe</i>	cify)
Attending Phir death.  ector: After thi by the funeral		27. Manner of Death  1 ဩNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time o Injury	Wor	yat k? Yes 2 □ No	28d. Describe how	w injury occurred	
tter lire n by	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (5	ipecity)			City or Town,		
To the Hospitel (within 24 hours at To the Funeral Discompletely filled in	edicai	29a. Certifier (Check only one)  Certifying Phy 2 Medical Exam	sician: To the best of m ner: On the basis of exa and manner stated	amination and/or in	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occ	e, and due to the caurred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
AC / To the within 2	Me	29b. Signature and title of certifier	famn			e number 2540(	- A	Ay 24	
YMS		30. Name and address of person who c	M.D., 900 S	SETON DRI		ERLAND, N	MD 21502		
Sta Regist		31. Date filed (Month, Day, Year)  MAY 2 5 201	32. Pegistrar's	Signature	perti				

		1	For State Registrar	State of M	Maryland		rtment of He		d Mental Hy	giene	006	176	04
			Decedent's Name (First, Middle, I	Last)					2. Date of De	eath	Vone	3. Time of	Death
	Physicia		RUTH H. HAYD	EN					MAY 12,	2006	Year	4:05	AM
	/Medic Examin		4a. Facility Name (If not institution, g	give street and number	er)		4b. City, Town, or	Location of D	eath	4c. Co	ounty of Death		
			9605 East Bexhill Dr				Kensington				gomery		
	Funeral		,	5. Sex 7 1 ☐ M 2 🖾 F	Age (In yrs. las	Vre	If Under 1 Year Months Days	Hours N	Vin. (Month, D	av. Year)	Coui	place (State o. ntry)	r Foreign
	Director		220-46-6911 Usual Residence of Decedent		93	113.			Septembe	er 12, 1	L912 GERMA	INI	
	land ow		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside Cit	ty Limits
	Mary -f eh	to	Maryland Montgome	erv	Kensin	gton						1 Ä Yes	2 🗌 No
	r 28a	irec	10e. Street and Number		4		10f. Zip Code			10g. Citize	n of What Cou	ntry?	
	th wit	Funeral Director	9605 East Bexhill Dr	rive			20895			U.S.A			
	ema erms	Iner	11. Marital Status	12. Was Decede Armed Force	es?	13. \	Was Decedent of His f Yes, specify Cubar	spanic Origin n, Mexican, P	? (Specify Yes or N Juerto Rican, etc.)	0- 14	<ul> <li>Race - Americal Black, White,</li> </ul>		
9	or it	by Fu	1 Never Married 2 Marner 3 X Widowed 4 Divorced	d 1 ☐ Yes 2   If Yes, Give Year or Date	_		1□Yes 2ĂNo	Specify:		S	pecify: Whi	te	
2-002p	within 72 hours after death with the Maryland ene. Iten "naturel", or itema 23a or 28a-f ehow Ite Medical Examinar must be notified at		15. Decedent's			16a. Deced	dent's Usual Occupa	tion		16b. Kind	of Business/In		
ņ	in 72	Completed	(Specify only highest	grade completed)		(Give	kind of work done d DO NOT use retired)	uring most of	working				
7 7	iene.	E	Elementary/Secondary (0-12)	College (1-4)		Admini	strative As	sistant		Federa	al Govern	ment	
<u> </u>	othe	0	17. Father's Name (First, Middle, La	ast)				18. Mother's	Name (First, Middle	e, Maiden St	итате)		
yland	uld by Menta Irked Itice	To B	Ernst	Haberland			1	Else		Richte	er		
Mar	and land land land land	i N	19a. Informant's Name/Relationship	p (Type, Print)		19b. Mailir	ng Address (Street a	nd Number o	or Rural Route Numi	ber, City or 1	Town, State, Zij	o Code)	13
≥ `	eelth m 27		Claus N. Felfe/Son		20h Blo		<ul> <li>Bedford Dr sition (Name of</li> </ul>	rive, Sa	an Diego, Ca Date		La 92116 ation - City or T	own State	
saitimore,	S T T T T T T T T T T T T T T T T T T T		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3	3 □Removal from Sta	000	netery, crer	natory or other place	1			•		
	tant:		4 □ Donation 5 □ Other (Spe		Fort		n Crematory		/19/2006		ood, Mar	yland	
a D	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelth and Mental Hygiene. Important: if item 27 is marked other than "naturet," or items 23a or 28a-f show mortant: if item 27 is marked other than "naturet," or items 23a or 28a-f show any intry or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Li	ensee .	^	ΗÍ	NES-RINALDI NES-RINALDI 800 NEW HAMI	FUNERAL	HOME, INC.	FR SPRI	ING MARY	TAND 20	904
			23a. Part1. Enter the disease, or c	complications that cau	ed the death.						ino, initi	Approximat	te
			shock, or heart failure. List o Immediate Cause (Final	nly one cause on eac	ch line.							Interval Bet Onset and I	
	Physician /Medical		disease or condition resulting in death)	a	tory Fail								
	Examiner			b. Adenocar			Lung						
	A.	je.	Sequentially list conditions, if any, leading to intribulate cause. Enter Underlying	D. Due to (ur	as a conseque	moe of):							
	cuted nd ransii	Examin	Cause (Disease or injury that initiated events	U			lmonary Dis	ease					
Š	ate be executed hysicien and the burial-transit		resulting in death) Last	Due to (or	as a conseque	ence of):							
8/60,	death certificate be executed e attending physicien and id foll use as the burial-transit	dicai	•	d		<u> </u>							
R9 X	leath certific attending pl	Physician/Med	IF FEMALE:	23c. If yes, outco	ome of pregnan	cv				23	d. Date of deliv	10 D/	
NO	atien fo us	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birt	h 2 Fetal on t at time of dea	death 3	Ectopic pregnancy Other (specify)			23	Month		Year
o.		ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknow									
J	res that igned by be deta		Part II. Other significant condition	1s contributing to dear	th but not result	ting in the u	nderlying cause give	on in Part I.	23e. Did	tobacco use	e contribute to	the cause of c	death?
<u>8</u>	n sign	ed by	Pancreatic Insuffic	iency					102	¶Yes 2□	No 3 ☐ Pro	bably 4 🔲	Unknown
Records	law requires that the as been signed by th 2 should be detache	Completed							24a. Wa	s an	24b. Were aut prior to co	opsy findings	available
Ä	The la	mo					*		per	opsy formed? 2 🔯 No	death? 1 ☐ Yes		ause or
Vital		Be C	25. Was case referred to medical					26. Place of	f Death (Check only				
>	Physician: r this certificated rall director, I	5	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 🗆 Inp	patient 2 E	R/Outpatier	nt 3□ DOA Othe	ar: 4 ☐ Nursi	ing Home 5 ☑ Re	sidence 6	□Other (Spec	(fy)	
n of		ü	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time o Injury	Worl		28d. Describe	how injury	occurred		
<u>S</u>	r Attending er death. rector: After by the fune	cati	2 ☐ Accident investigation in	ation of he	41.1			Yes 2 □No		(Street and	Number or Rui	ra I Pauto Alua	nhos
Division	a # # # E	Certification:	4 Homicide determin	ned 200. Flace O	g, etc. (Specify)	ne, rarm, st	reet, factory, office			own, State)	TVBITION OF THE	ar rioble ivair	1001,
_	Hospital 24 hours a Funeral C		29a, Certifier 1 X Certifying	Physician: To the b	est of my know	iledge, deat	h occurred at the tim	ne, date and i	place, and due to th	e cause(s) a	ind manner as	stated.	
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical		xaminer: On the bas and manne	is of examination								s)
	To the H within 24 To the F	Me	29b. Signature and title of garifier	ALAA			29c. License	number		29d. Date	signed (Month	, Day, Year)	
	33	1	July 4/	444			Н45839			May 15	, 2006		
			30. Name and address of person v					mon' '	ADVI AND 200	1/.			
			GARY RAFFEL, M.D.,					шSDA, М	AKILAND 208	14			
*	St Regist	ate trar	31. Date filed (Month, Day, Year)	2006	gistrar's Signati	Sign	who .						
	A 0			1000		-							

		1	State of Maryland / Department of Health and Mental Hygiene  State of Maryland / Department of Health and Mental Hygiene  23,25,8 per Dr/FH C856 06 05 06 176  Reg. No. 2 0 6 76	05
	Physicia /Medic Examin	in al er	Decedent's Name (First, Middle, Last)  ANN KENNARD HATHAWAY  2. Date of Death Month Day Year 3. Time of Decedent's Name (If not institution, give street and number)  4b, City, Town, or Location of Death EASTON  3. Time of Decedent's Name (If not institution, give street and number)  4c. County of Death TALISOT  3. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Formal Security Number)  9. Birthplace (State or Formal Security Number)  9. Birthplace (State or Formal Security Number)	2™
	Funeral Director		1 M 2 F 83 Yrs. Months Days Hours Min. (Month, Day, Year)  1 M 2 F 83 Yrs. Months Days Hours Min. (Month, Day, Year)  1 Jeual Residence of Decedent  10a, State 10b, County 10c, City, Town or Location 10d, Inside City L	_imits
	the Maryla 28a-1 sho	ector	MO TALBOT EASTON  1 Yes 2 To the street and Number 109. Citizen of What Country?	₩vo
	s 23e or	Funeral Director	8161 LEE HAVEN ROAD 21601 USA  12 Was Decedent of Hispanic Origin? (Specify Yes or No. 14, Race - American Indian,	
036	ours after de ral', or Item Examinen	by	Armed Forces?  1 Never Married 2 Married  3 Widowed 4 Moivorced  Armed Forces?  1 Never Married 2 No Specify:  1 Yes, Give Year or Dates:  1 Yes 2 No Specify:  1 Yes 2 No Specify:  Specify: WHITE	
21215-003	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It health and Mental Hygiene item 27 is marked or hygiene them "natural", or Items 23e or 28a-f show other them." The Medical Examinating that he millied at other treumatic event, the Medical Examinating that he millied at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  HONEMAKER  OUN HOME	
Maryland 2	ould be filed with Mental Hyglene arked other tha atic event, he	ro Be C	17. Father's Name (First, Middle, Last)  LAURENCE JOSEPH HATHAWAY  ANNE EARLE	
2	1 and 2 shou Health and N em 27 Is ma sther treuma		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  3602-204" ST. NE ARLINGTON WA 9822	3
Baltimore,	Pages 1 and of He ant: If item		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State  20c. Location - City o	
Balti	permit. Page Department o Importent: If eny injury or once.		21. Signiture: Funeral Service Licensee  22. Name and Address of Eacility EXAL HOME WILLIAMSON FUNEXALSBURGMO 21632	
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Enterval Enter	en ath
	/Medical Examiner		Due to (fras a consequence of):  Sequentially list conditions  b. As proton promounts 1) x day	5
	be axecuted ician and burial-transit	Examiner	if any, leading to immediate Dile to (1998 a contest of)	
8760,	cate be ax ohysician a the burial	ical	C C C EDICAL	
P.O. Box 68	that the death certificate be executed ed by the attending physician and delached for use as the burial-transit	Physician/Med	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	àr
	v requires that i been signed by should be deta	by	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part I.  1 Yes 2 No 3 Probably 4 Onk	
Vital Records,	e lav has	Completed	autopsy performed?  1 yes 2 No  24a. Was an autopsy performed?  1 yes 2 No	ailable se of
	siclan: certific rector,	o Be C	25. Was case referred to medical examiner?  1	
on of	ding Phys h. After this funeral di	H-	27. Manner of Death    28a. Date of Injury   28b. Time of Injury	
Division	or Attending after death. Director: After	Certification:	3 Suicide 6 Could not be determined 6 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of City or Town, State)	ν,
	To the Hospitel or Attending F within 24 hours after death.  To the Funerel Director: After completely filled in by the funer.	Medicai C	29a. Certifier  (Check only one)  12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
)	To the within 2 To the comple	Me	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  D 577 860  May 11, 2006	
	D+1		296. Signature and title of certifier  250. Signature and	01
	St Regist	ate rar	31. Date filed (Month, Day, Year)  JUN 0 5 2006  32. Registrar's Signature	

			For State Registrer		Marylar			nt of H				eg. No.	006	17606
	Physici /Medic		Decedent's Name (First, Middle, L.     Arthur	ast)		Hub	bard				2. Date of Deal Month May 12	Day	Year 6	3. Time of Death 4:45P
**	Examin		4a. Facility Name (If not institution, g. Civista Medical  5. Social Security Number 6.	Center	nber) 7. Age (In yrs.	last birthday	La	Plata riyear	Location of a If Under 2		8. Date of Birth	Ch	arles	
∞ Di	uneral irector		324-07-3425 Usual Residence of Decedent	<b>XXX</b> 2□ F	90	Yrs.		Days	Hours	Min. J	8. Date of Birth (Month, Day uly 24,	, Year) 1915		hplace (State or Foreign buntry) SSISSIPPI
1 <b>215-0036</b> within 72 hours after death with the Maryland ene	important: if terms 27 is marked other than "naturel", or tieme 23a or 28e-1 show eny injury or other traumatic event, in Medical Examinar must be nytified at once.	Funeral Director	Maryland Prince (  10e. Street and Number  12204 Hazel Hill C:			ty, Town or Li Vashingt	on	ip Code	20744		1	0g. Citizen	of What Co	10d. Inside City Limits 1 Yes XXNo
<b>036</b> ours after death	rel', or iteme 23 Examinar mus	by Funera	11. Marital Status  1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Dece Armed Fo	2 □ No e	J.S. 13.	Was Dec If Yes, sp		ispanic Orig n, Mexican, Specify:	gin? (Spec , Puerto F	ofy Yes or No- lican, etc.)		Black, White	orican Indian, e, etc. lack
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hydiene	nerthan "naturit, the Medical	Completed by	15. Decedent's (Specify only highest g	rade completed) College (1	-4or 5+)	life.	kind of w	ork done d use retired	during most			Auto	Indust	
aryland should be fil	narked oth	To Be	17. Father's Name (First, Middle, Last Oliver Hubbard			19h Maili	ing Addre	es (Street	Ida	a Mae	(First, Middle, i Cain Route Number			Zin Code)
e, Mal 1 and 2 st Health and	em 27 is r thar traur		Kimberly Walton / De		20b.	12204	Haze	Hill	Circle	e Ft.	Washingto	on, Mai	yland	20744 Town, State
Baltimore, permit. Pages 1 a	ortent: If It injury or o		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service, Lice	city) n	State	cemetery, cre irrectio	n Cem	etery	Ma	ay 17,		Clinto	on, Mar	yland
B §	eny ir		23a. Parl 1. Enter the disease, or co	e p	aused the dea	6	160 0	kon Hi	11 Road	1 Oxon	Hill, Ma	aryland		
	sician ledical		shock, or heart faifure. List on fmmediate Cause (Final disease or condition resulting in death)	y one to e on e	ach line.  ANCE or as a consec	DA			Cla				- Personal	Interval Between Onset and Death
760, te be executed	physician and ithe burial-transit	dical Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated seents resulting in death) Last	c	or as a consec									3
Records, P.O. Box 68 The law requires that the death certifice	igned by the attending ph be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		irth 2 ☐ Feta ant at time of c	al death 3	⊒Ectopic ⊒ Other (	pregnancy specify)				23d	Date of del Month	ivery Da <b>y</b> Year
Records, P.	en signed by		Part II. Other significant conditions	contributing to de	eath but not re	sulting in the t	underlying	cause give	en in Part I.		23e. Did tol	_		o the cause of death?
	is certificate has in director, page 2 sh	Completed										ned? No	4b. Were au prior to death?	utopsy findings available completion of cause of 2  No
of Vital Physician:	is certil directo	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	npatient 2	ER/Outpatie	nt 3□ [	Othe			Check only on		Other (Spe	cify)
D ding	After th funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat	on	of Injury h, Day Year)	28b. Time of fnjury	of M	28c. Injun Work		2	8d. Describe ho			
Division	To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not determine	d 286. Place buildi	of fn <sub>f</sub> ury - At h ng, etc. <i>(Speci</i>	ify)					City or Town	n, State)		ural Route Number,
Hospital	Fune Fune etely fil	edicai	29a. Certifier (Check only one) Certifying I	hysician: To the aminer: On the ba and mana	best of my kn asis of examin ner stated.	owledge, dea ation and/or in	th occurre nvestigation	d at the timen, in my of	ne, date and pinion, deat	d place, a th occurre	nd due to the c d at the time, d	ause(s) and ate and pla	d manner as ce, and due	stated. to the cause(s)
To the	To the	Me	29b. Signature and title of certifier	IAN 8	0	- M		9c. License			2	9d. Date s	gned (Monti	h, Day, Year)
R	4		30. Name and address of person who George H. Wathe	n.MD 113	45 Pemi	hrooke	Saua	re Su	uite 1	LO3 W	aldorf,	Mary	land	20603
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  MAY 1 9 700	6	egistrar's Sign	HILLIAN TO A	Les .							

			For State Registrar	State of Ma	-	epartmer Certificat			Mental Hy	giene	006	17607	
			1. Decedent's Name (First, Middle,	Idle, Last)						eath Day	Year	3. Time of Death	
	Physici: /Medic		John Joseph			Hanekamp				22	2006	18:35 M	
	Examin		4a. Facility Name (If not institution,	give street and number)		4b. City,	Town, or	Location of De	ath	4c. Cd	ounty of Dea	th	
			MEMORIAL HOSPITA				IBERL				EĢANY		
	Funeral		5. Social Security Number 6	5. Sex	(In yrs. last birth	rs. If Under	r 1 Year Days	If Under 24 H Hours M		rth a <i>y, Year)</i>	9. Bir	thplace (State or Foreign ountry)	
	Director		220-38-0708	6	2 '	15.			09/01	1943	Mary	land	
	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 ie marked other than "natural", or Itema 23a or 28a-f ehow other traumatic event, the Madical Examiner must be notified at	Director	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits	
			MD Alle	na ny		Cumb	orlai	nd				1√ Yes 2 No	
			MD Allegany  10e. Street and Number			10f. Zip Code					n of What Co	ountry?	
	with Sa or	ā	229 Baltimo	ro Amonuo			2.	1502		USA			
	Jeath The 2:	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Dece			(Specify Yes or Nerto Rican, etc.)		Race - Ame	encan Indian,	
(0	r Iter	F	1 Never Married 2 Marrie	Armed Forces? d 1 ☐ Yes 2 ☑ N	0				өпо нісап, етс.)		Black, Whit	te, etc.	
21215-0036	al', o	þ	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give 'Year or Dates:		1 ☐ Yes 2 ☐ No Specify:				5)	pecify:	White	
	72 ho	etec	15. Decedent's (Specify only highest		16a.	Decedent's Usu (Give kind of wo	al Occupa	ation during most of v	vorking	16b. Kind	of Business	/Industry	
7	thin a	Completed	Elementary/Secondary (0-12)	College (1-4or 5-		life. DO NOT u	ise retired	)					
7	ygier ygier it, the	S	12			Police	Off:		1 (Circh Addd)		icipal	l	
Baltimore, Maryland	be fill H d off	Be	17. Father's Name (First, Middle, La	as <i>t)</i>				18. MOTHERS N	lame (First, Middl	e, maiden St	тате)		
	Men Men Marke	၉	William	Albe		anekamp		Elsi	e Ma Rural Route Num	rie		mphrey	
	12 sh and le m		19a. Informant's Name/Relationshi		1	and the same				er englischen	own, State,	Zip Code)	
	l and lealth im 27 her t		Johnna A. Shrev 20a. Method of Disposition	e / daughter		63, Bo Disposition (Na	x 12	50, Rom	ney, Wes	Virg	inia	26757 Town, State	
	in of the		1 X Burial 2 ☐ Cremation	B □Removal from State	cemeter	r, crematory or	other plac			200. 0000	alon only or	Town, Olato	
	permit. Pages Department of the Important: If Ite any Injury or of ones.		4 Donation 5 Other (Spe		Greenm				26/2006		erlan		
39	Deperment Import		21. Signature of Funeral Service Li	censee		22. Name a				•		1 Home, P.A.	
-	ØD3 € Ø		Thete. U	an	Aba dasab Daga				et, Cumb		, MD	21502 Approximate	
	eath certificate be executed  attending physicien and attending physicien and for use es the burial-transit		shock, or heart failure. List o	e.	<ul> <li>Do not enter the mode of dying, such as cardiac or respiratory arrest,</li> </ul>						Interval Between Onset and Death		
			Immediate Cause (Final disease or condition resulting in death)	_aLIVER F	LIVER_FAILURE							5 YEARS	
			resolung in death)	Due to (or as a consequence of):									
		_	Sequentially list conditions		CIRRHOSIS OF THE LIVER								
		Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	Due to (or as a consequence of):								
		xan	that initiated events resulting in death) Last	C. Due to (or as a	Due to (or as a consequence of):								
760,	be e icien buria	calE											
687	icate phys			U.									
×	certif Iding Ise e	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy						23d. Date of delivery		livery	
Records, P.O. Box	atter for u	ciar	in the past 12 months?		1 Live birth 2 Fetal death 3 Ectopic pre 4 Pregnant at time of death 5 Other (spe					Month Day Year		Day Year	
	thet the death ed by the atte detached for	ysi	9 Unknown	9□ Unknown									
	The law requires thet the death certifica te has been signed by the attending ph page 2 should be detached for use es th	by Pi	Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							tobacco use	bacco use ontribute to the cause of death?		
	quires n sign uld be	D D	CHRONIC OBSTRUCTIVE PULMONARY DISEASE							☐ Yes 2 No 3 Probably 4 ☐ Unknown			
	w requir	iete	CANCER OF THE L						24a. Was an 24b. Were autopsy findings				
æ	The lav	Completed	OMNOBIA OF THE E						autopsy prior to completion of cause of death?  1 Yes 2 W No 1 Yes 2 No				
Division of Vital		a	25. Was case referred to medical	1   Yes 2   W No   1   Yes 2   No     No     Yes 2   No     Yes 2   No     Yes 2   No   Yes 3   No   No   No   No   No   No   No									
	Physicien: this certific ral director.	0 8	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
	er thi	n:	27. Manner of Death	28a. Date of Injury 28b. Time of 28c. Injury at 28d. Descr						how injury	occurred		
	Attending I r death. ector: After by the funer	atlo	1 Vatural 5 ☐ Pending 2 ☐ Accident investiga		M								
V <sub>i</sub> S	il or Attend after death i Director; , d in by the f	ific	3 Suicide 6 Could no 4 Homicide determine			rm, street, facto	ry, office			(Street and i	Number or A	lural Route Number,	
ō	s after or all Display	Certification:											
	To the Moepital or Attending 24 hours after de To the Funeral Directo completely filled in by the											s stated. e to the cause(s)	
	the H in 24 the F iplete	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pi										
	To T		29b. Signature and title of certifier	1	29c. License number 29d.					MAY 22 in Sol 6			
	2		16 basto	Janes 4									
	nes		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										
	1110		DR. ROBUSTIANO BARRERA, 500 MEMORIAL AVE., SUITE 201, CUMBERLAND, MD 21502										
		ate	31. Date filed (Month, Day, Year) MAY 2 3	1 10	ar's Signature	Locale							
	Regist	rai	MINITO	UUD Additions	الميان سا	Sales Sales	,						

State of Maryland / Department of Health and Mental Hygiene 2 () () 6 Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death May 30, 2006 **Physician** James Rav Hagen 04:30 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frostburg Allegany 104 Frost Avenue If Under 1 Year | If Under 24 Hrs. 5. Social Security Numbe 529-52-8666 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 23-Mar-1941 9. Birthplace (State or Foreign Country) **Funeral** Days 1**√**M 2□F 65 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ?7 is marked other than "natural", or Items 23a or 28a-f show traumatic avant, Its Medical Examinar must be notified at Maryland 1 Yes 2 No Frostburg Allegany Director 10e. Street and Number 104 Frost Avenue 10f. Zip Code 10g. Citizen of What Country? 21532-U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, 11 Marital Status Black, White, etc. ☐Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2**X** No Baltimore, Maryland 21215-0036 Specify: White Specify: λq 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) professor state university permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic avant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ray Hagen Dorothy Hills 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1849 E. 7880 S.

South Wahar Titch 19a. Informant's Name/Relationship (Type, Print) Tobin Hagen South Weber Utah 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cumberland Crematory 03-Jun-2006 Cumberland Maryland `4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Approximate Interval Between Onset and Death Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final METALTATIC **Physician** LIVERLCARCINOMA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last iding physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? LIVER CIRRITOSIS 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Lesidence 6 Other (Specify) 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) PITYSICIAN 05/20/06 D50844 10 912 SETON DILLVE npleted cause of death (Item 23a) (Type, Print) 30. Name and address of person with DUPRIA JR. COMBURGAD MD 21502 31. Date filed (Month, Dly, Year) State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

amend State of Maryland y Department of Health and Mental Hygiene

				State of Ma	ryiano	•			Death		leg. Na <sup>2</sup> 0 (	16	17609
	rat		Amend#26.Per Phys.PG 1. Decedent's Name (First, Middle, Li	5-18-06cr est)			imou		Doui!!	2 Date of Dec	th	<i>J</i> ( <i>J</i>	3. Time of Death
	Physicia /Medic	al	CORTNE	o. KI	NG					May 1	2, Day 2006	5 Tear	4:20 PM
	Examin		4a Facility Name (If not institution, gi						4b. City, Town, or	Location of Death	4c. County		
			835 Laurel La		//m //	nat himbota.	If I Indi		LaPlata If Under 24 Hrs	0 0-1(0'-4	Char		lace (Chata au Familia
	Funeral Director			1□M 2□F	7 6	ast birthday) Yrs.	Months		Hours Min		1 9 3 0	Wast	lace (State or Foreign try) nington D(
	yland	Ì	10a. State 10b. County		10c. City	, Town or Loc	ation					10	Dd. Inside City Limits
	the Mar 28a-f sh	Director	D . C .		Was	hingt	1	ip Code		1 .	0g. Citizen of W	/hat Coun	1 X Yes 2 □ No
	3a or	直	1200 Delaware	Awanua	c ti	#425		2002	/.		U.S.A		
020	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "netural", or Items 23a or 28a-f show other traumatic svent, the Medical Examiner must be restlined at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Midowed 4 Divorced	12. Wes Decedent E Armed Forces? 1  Yes 2 N If Yes, Give Year or Dates:	ver in U,S	S. 13. V	/as Dec Yes, sp			Specify Yes or No- to Rican, etc.)	14. Race Black	America K, White, C	etc.
21215-0020	within 72 ho ene. then *natura he Modeal	Completed by	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12) 1 2 t h	ducation ede completed) College (1-4or 5-	+)		ind of w O NOT	ork done use retire	during most of wo d)		16b. Kind of Bu		lustry
<b>d</b> 2	Hygie Hygie ont,	ပ္မွ	17. Father's Name (First, Middle, Les	t)		Main	Len	ance	Worker 18. Mother's Na	me (First, Middle,	Priva Ma <i>iden Sumam</i>		
lan	lid be lental kad o ic sve	To Be	Ernest Griff	ith					011ie	Dent			
Maryland	2 should and N is mar		19a. Informant's Name/Relationship					,		u <i>ral R</i> oute Numbe			
	and and in 27 in 27 in and training	1	Zsanetta A. Ki	ng, daugh			-		Lane, 1				
Baltimore,	Pages 1 ent of H nt: If iten ry or oth		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 [ 4 □ Donation 5 □ Other (Speci		Ce	ace of Dispos metery, crem t I.i.n	atory or	other plac			20c. Location - (		wn, State Maryland
Balti	permit. Pages 1 Department of H Important: If ite any Injury or ot once.		21. Signature of <b>Ferreine</b> vice <b>At</b>	stin per d	vr	22.	Name a	nd Addre	ss of Facility H	ALL BRO	THERS 1	FUNE	RAL HOME
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused to one cause on each line	the death	. Do not ente	r the mo	de of dyir	ng, such as cardia	c or respiratory arr	est,		Approximate Intervel Between
	Physician Line di Examiner	_	Immediate Cause (Final disease or condition resulting in death)	a. <u>750</u>	bue to (or	as a consequ	uence of	12 Ca	rt	Disa	S	1	Onset and Death
,	icate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	Oue to (or	as a consequ	ience of	):					
x 68760,	tificate be ng physicia as the bu	Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last	c	ue to (or	as a consequ	ence of)	:	,			† 	
Box	eath cer attendin I for use	lan/		u									
P.O.	uires that the de n signed by the a uld be detached f		Part II. Other significent conditions	contributing to death but	not resul	iting in the un	derlying	cause giv	en in Part I.				the ceuse of deeth?
of Vital Records,	red Shou	Completed by					*			24a. Was a perfor		ava	re autopsy findings ilable prior to npletion of cause leath?
<u>~</u>	The law cate has l	E								104	s 2MNo	1 🗆	Yes 2□ No
/ita	ician: Th certificate rector, pa	Be	25. Was case referred to medical examiner?							ath (Check only or	Θ)		E LI
	ding Physion h. Atter this continues of funeral dire	tion: To	1 ⊠Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		R/Outpatient 28b. Time of Injury		28c. Injur Wor	4 — Naising i	lome 5 2 reside			Residence
Division	al or Attending P s after death. Il Diractor: After ti ed in by the funera	Certification:	2 Accident Investigation 3 Suicide 6 Could not to determined	e One Place of Injur			et, facto	ry, office		28f. Location (S City or Town		r or Rural	Route Number,
	2 5 6 5	edicai		miner: On the basis of and manner stat	examination								
	Vithir To th comp	¥ E	29b. Signature and title of certifier					-	e number		9d. Date signed	,	**
			Jania s	. Jugar	(V),			100	05088	3	5/15/	1200	6
R	(3)		30. Nam- and address of person who	completed cause of de-	ath (Item	23a) (Type, F	rint)	10	2064	5			
	Stat Registra	<b>-</b>	31. Date filed (Month, Day, Year)	. Registrar	's Signate	ure-	K)						

06-03487

Amended Item 10e per F.H. 05/31/2006 Carroll County, wjl Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene

Kaye Frances Kepley

2006 17610

		For State		Certifica	ate of	Death		R	eg No.	700	1701
Physiciar		. Decedent's Name (First, Midd	le,Last)					Date of Dea     Month	th Day Year		e of Death
Medical Examin		Kaye France	es Kepley					May 22, 2		220	05 hrs
	4	a. Facility Name (if not institution	on, give street and number)		41	o. City, Town, or Lo	ocation of Deal	th	4c. County of		
		24 Mooring Point Cou	ırt			Annapolis			Anne Aru		
Funeral	. 5	Social Security Number	6. Sex 7. Age	(In yrs last birt	hday)	If Under 1 Year	If Under 24Hi		th (MM/DD/YYYY)	9. Birthplace Foreign	(State or
Director		315-72-5305	1 M 2 X F	38	Yrs.	Months Days	Hours Mi	n. Sept.	25 1967	Country)	MD
	-	Jsual Residence of Decedent						DOP 0			
aux		0a. State 10b. County		10c. City, Town						10d Ir	nside City Limits
ž .		MD Ani	ne Arundel		Annaj	polis				1 X	Yes 2 No
Maryland 28a-f show 1 at once.	Director	Oe. Street and Number 7	4 Mooring Po	int Ct		10f. Zip Code		1	0g. Citizen of Wha		
e Mar	ē	24 Morring P	oint Ct	Inc oc.		21	L403		USA	A	
		11. Marital Status	12. Was Decedent	Ever in U.S.	13 Was	Decedent of Hispa	anic Origin? ( 5	Specify Yes or No	- 14 Race	- American Ind	ıan, Black,
tth w	<b>≖</b> ।		arried Armed Forces?			s, specify Cuban, I			White		
2 5 E	ᆵ		1 Yes 2	X No	1	Yes 2 X No	specify		Specify:	White	
5-0036 led within 72 hours after Hygiene "natural", other than "natural", the Medical Examine.	⋧┝	3 Widowed 4 Di  15. Decedent's Education (Spe	or Dates.	nleted) 16a		s Usual Occupatio		f work done	16b. Kind of Bus		
hour Faar	Completed	Elementary/Secondary (0-12				st of working life. [					
36 in 72 han tical	흺	Elementary/Secondary (0-12)	2		Set+1	ement Off	Ficer		Rvan	Homes	
with giene ner th	팅	17. Father's Name (First, Middle		<u> </u>	CCCI			ne (First, Middle,	Maiden Surname)		
filed Hygid off								e Blair			
21215-0036 uld be filed within 7 Mental Hygiene marked other than	e B	Thomas Alvi 19a. Informant's Name/Relation		19	b Mailing	Address (Street)			mber, City or Town	n. State. Zip Co	ode)
O 8 8 8 8	ř			1		Monroe Ma			nsville,		
Baltimore, MD pennit Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati	-	Thomas A. Kep	1ey/rauler	20b. Place		tion (Name of ceme		Date	20c. Location -		
Baltimore, permit Pages I ar Department of Hee Important: If ite		1 XBurial 2 Crematic	n 3 Removal from Sta	ate cremat	tory or oth	er place)	İ	- 100 100			
Page nent ant: or ot		4 Donation 5 Other S	Specify:	Meado		anch Cem			06 Westr		
alti mit partn port		21. Signal le eral Strur	Licensee		22 N:	ame and Address of	of Facility Prall Ho	ome and	Chapel, 1	P.A.	1117
<b>™</b> % % % % % % % % % % % % % % % % % % %		Mall II de	or complications that caused		11	2 Washin	rton Ro	ad Wes	tminster	, MD <sup>2</sup>	21157
Physician	1	23a Part I Enter the disease, of tailure List only one caus	or complications that caused e on each line.	the death. Do no	ot enter th	e mode of dying, s	dch as cardiac	or respiratory ar	rest, shock, or hea	irt Appr Betv	roximate Interval ween Onset and
/Medical		Immediate Cause (Final diseas	T): -14-: -	Ketoacido	sis					1.	Death
Examiner	- 1	or condition resulting in death)	Due to (or as a cons								
	- 1	Sequentially list conditions,	b							_	
	miner	if any, leading to immediate cause. Enter Underlying Caus	Due to (or as a cons	equence of):							
	Ē	(Disease or Injury that I litiated	Due to (or or a cons	equence of):			_				
ed nsit	Exal	events resulting in death) Last	d	- 44.0							
wecu n and	등	XUNPENDED		em#23a.27	.perM	E,g856,6/12	/06 TT				
8760, ificate be executed gphysician and sthe burial - transit	n/Medical	1			-		, 00 11		23d Date of	delivery	
8760, inficate being physic as the bur	[	IF FEMALE: 23b Was decedent pregnant in	the 23c. If yes, outcome the Live birth		2 Fet	al death 3	Ectopic preg	inancy	Month	Day	Year
certi	lä.	past 12 months?	-	41 6 - 1 4le	- =	ner (Specify)		,			
Box 6 le death cert the attendii	Physicia	1 Yes 2 No 9 🗸 U	nknown 9 Unknown			101 (1-1)			1		
Vital Records, P.O. Box 685 hysician: The law requires that the death certifithis certificate has been signed by the attending at director, page 2 should be detached for use as a		Part II. Other significant cond	litions contributing to deat	h but not resultir	ng in the u	nderlying cause gr	ven in Part I.	23e Did	tobacco use contri	bute to the cau	use of death?
P.C	ρ							1 Ye	es 2 No 3	Probably	4 🗸 Unknown
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rasher death  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach	Completed							24a Was	1		indings available
aw re	흷							auto perf		rior to complet leath?	ion of cause of
Rec The l	팃							1 🗸 Yes	2 No 1	<b>✓</b> Yes	2 No
al F	Be	25. Was case referred to medie examiner?					of Death (Che				
Vit ysich this o	.0	1 ✓ Yes 2 No	Hospital. 1 Inpati	ent 2 ER/C	utpatient	3		sing Home 5	Residence 6		e
nof ing Pt After funeral		27. Manner of Death	28a. Date of Inj (Month, Day,		Time of I		y at Work?	28d Describe	how injury occurr	ed	
on endii sath or: A	Certification:		nding vestigation			1Y	es 2 No				
r Att r Att ler de lirect n by	اق		28e. Place of I	njury - At home,	farm, stree	et, factory, office bu	uilding, etc.	28f, Location or Town,	(Street and Number	er or Rural Ro	ute Number, City
Div	뒫		termined (Specify)					Or TOWIT,	olate)		
Hospital 24 hours Funeral etely fille		29a. Certifier 1 Certifying	Physician: To the best of r	ny knowledge, de	eath occur	red at the time, da	te and place, a	and due to the car	use(s) and manner	as started	
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certif completely filled in by the funeral director.	Medical	one) 2 Medical E	xaminer:On the basis of exa	amination and/or	investiga	tion, in my opinton,	death occurre	d at the time, dat	e and place, and d	lue to the caus	e(s)
To with To con	Mec	29b. Signature and title of cert	and manner stated			29c License	number		29d Date sign	ed (Month, Da	y, Year)
	7	Quint	`			O.C.N	Л.E.		May 23, 20	006	
inst		- July	control of the contro	dooth (Hom 22-)							
Mo		30. Name and address of pers Ana Rubio MD. A	on who completed cause of ssistant Medical Exal			Street, Baltimo	re. MD 212	201			
St Pegis	ate	31 Date filed (Month, Day, Yea MAY 3 1	"2006 <b>Com</b>	ar's Signature	Span	W					

DHMH 17 Rev 1/2001

Registrar

31. Date liled (Month, Day, Year)
MAY 1 9 2006

32. Registrar's Signa

			For State	State of Mary		artment of H			201	06 17612
			Registrer  1. Decedent's Name (First, Middle,	f oot)	061	tilicate of t	Jealii	2. Date of Deat	eg. No. C. U	3. Time of Death
	Physicia							Month	Day Ye	ear
	/Medic	al	Anthony Cliffor			41 00 7		May	20 200 4c. County of I	111.002
	Examin	C.	4a. Facility Name (If not institution,		_		Location of Death			
			Berlin Nursing &			Berli If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Worces	Birthplace (State or Foreign
	Funeral		5. Social Security Number 6	i.Sex 7. Age (In 7. A	yrs. last birthday) Yrs.	Months Days	Hours Min.	(Month, Day,	Year)	Country)
	Director	-	387-22-7097 Usual Residence of Decedent		, , ,			02/02/1	921	WI
	and w	}	10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits
	/anyl	ō	MD Worces	tor	cean Pin	A.C.				1 ☐ Yes 💥 🕅 No
	28a-	Director	MD Worces  10e. Street and Number	tel	cean III	10f. Zip Code		1	0g. Citizen of Wha	at Country?
	with re r			- 1		21811			USA	,
	eath	eral	19 Brookside Ro	12. Was Decedent Ever	in U.S. 13.1		ispanic Origin? (Spe			American Indian,
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heatile and Mental Hygiene. Depertment of Heatile and Mental Hygiene. Important: If term 27 is marked other than "natural", or items 23a or 28a-f show eny folury or other treumatic event. The Medical Examinar mount term citied at once.	by Funeral	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? d 1XXYes 2 □ No	1	f Yes, specify Cuba 1 ☐ Yes 2XXXNo	ispanic Origin? (Spe an, Mexican, Puerto Specify:	Rican, etc.)	Specify:	White, etc. White
ŏ	2 hou	Completed	15. Decedent's		16a. Deced	dent's Usual Occup	ation		16b. Kind of Busin	ness/industry
715	n'n'	ble	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	during most of worki f)	rig		
212	r the	E	Lienteritary/Secondary (5 12)	4	Deput	y Directo	or	Г	ransport	ation Engineer
פ	et et et et et et et et et et et et et e	Be C	17. Father's Name (First, Middle, La	ist)			18. Mother's Name	(First, Middle, M	Maiden Sumame)	
lar	id be lenta ked ic ev	To B	Edward Kanz				Anna Krei	n		
Ž	2 should be filed wo and Mental Hygier to marked other to reumatic event.		19a. Informant's Name/Relationshi	p (Type, Print)	19b. Mailir	ng Address (Street	and Number or Rura	I Route Number	, City or Town, Sta	ate, Zip Code)
Ž	nd 2 lith a 27 ie r trei		Patricia Kanz (	wife)	19 B	rookside	Rd. Ocean	n PInes,	MD 2181	1
<u>(</u>	Heal Heal Heal Heal Heal		20a. Method of Disposition		0b. Place of Dispo	4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			20c. Location - Cit	
μQ	ages ant of t: If i		1 ☐ Burial XX Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			open Cre		2/2006	Frankfor	d, De
Baltimore,	ortan ortan Injur		21. Signature of Funeral Service Li			2. Name and Addre		_	uneral H	
Ba	Depe Depe Impo eny ir		MARALIGLIA	y tras	1		am Street	_		
			23a. Part1. Enter the disease, or co shock, or heart failure. List o	omplications that caused the						Approximate
			shock, or heart failure. List o	11-1	1 1	C -11	.m . 1	0.5		Interval Between Onset and Death
<i>j</i> 1	Physician /Medical		disease or condition resulting in death)	a. AVherosc	leone	Cercus	ve xula-	Ulxa	2 e	Teurs
	Examiner			Due to (or as a co	nsequence of):					
		<u></u>	Sequentially list conditions,	Due to (or as a co	nsequence of):					
	ed sit	lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 to (or us a co	risoquorios cij.					
	and and I-tran	Examine	that initiated events resulting in death) Last	c Due to (or as a co	nsequence of):					-
8760,	The law requires that the death certificate be executed tte has been signed by the attending physicien and tage 2 should be detached for use as the burial-transit									
87	cate l	dicai	`	d						
9 X	leath certific attending pl	₩.	IF FEMALE:	23c. If yes, outcome of pa	regnancy				00.1 0	d dell'oran
Box	ath c	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal death 3	Ectopic pregnancy	′		23d. Date of Month	
0	the a	/slc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time 9☐Unknown	ordeath 5	Other (specify)				
Д.	that the de led by the a detached	F.	Part II. Other significant condition	s contributing to death but or	at resulting in the u	inderlying cause giv	en in Part I	23e. Did tol	bacco use contribu	ute to the cause of death?
Š,	res t signe be d	ğ	Turrii. Ottor organization	o common and to common and				1 🗆 Y	es 2 □ No 3	Probably 4 Doknown
of Vital Record	w requir been s should	ompleted							T	
ec	law lasb	ple						24a. Was a autops	sy prio	re autopsy findings available or to completion of cause of
<u> </u>		Con						perform 1 ☐ Yes		ith? I Yes 2□ No
ita	sian: ] artifical ictor, p	Be	25. Was case referred to medical examiner?				26. Place of Deat	n (Check only on	10)	
=	Physician: this certific ral director,	ဂ္	1 ☐ Yes 2 No	Hospital: 1   Inpatient	2 ER/Outpatie	nt 3 DOA			ence 6 Other	
		ü	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time o lnjury	Wo		28d. Describe ho	ow injury occurred	
0	Attending r death. ector: After by the fune	atl	2 Accident investiga	ation		M 1	Yes 2 □No			
Division	- 2 5 7	Certification:	3 Suicide 6 Could no 4 Homicide determin	28e. Place of Injury - building, etc. (S	At home, farm, st. Specify)	reet, factory, office		28f. Location (Si City or Town		or Rural Route Number,
	ppital or ours afte neral Div filled in	Se	. ,							
	To the Hospital o within 24 hours at To the Funeral D completely filled in	edical		Physician: To the best of m xaminer: On the basis of exa and manner stated.	amination and/or in					
	To the Hos within 24 h To the Fun completely	Med	29b. Signature and title of certifier	and marrier stated.	·	29c. Licens	se number	2	9d. Date signed (	Month, Day, Year)
	F ≱ F 8		W// X7/	entel.		Do	8769		5/21	106
			110000	to complete the	1/10= 22=1.77	Prior)	0,01	1	2/01	iAn
1	9+1		30 Name and address of person v	Dorodulla 1	(item 23a) (Type,	209 (	e) astal	Heelenx	- Few	de Stal De 1949
1	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	•	U 1-0(	June	1	-171/-0
	Regist		MAY 2	2 2006	V K A	pode				

			ricas	State of Ma			artment of I			-	e .	
		•	For State Registrar	3.4.3 3	, ,		rtificate of			Reg. N		17613
			1. Decedent's Name (First, Middle,	Last)	-		120-0		2. Dat	e of Death	ay Year	3. Time of Death
	Physicia /Medic		JOSEPH	CHARLES			KOZAI	, III		5 2	06	12110 P.M
	Examin		4a. Facility Name (If not institution,	1 11	<b>L.</b> 1		4b. City, Town,	1 /	1	4	lc. County of Dea	
			Sacred Hec			- 1 - 1 - 1 - 1 - 1	If Under 1 Year	If Under		o of Dinth		zany
	Funeral		5. Social Security Number 578–80–7950		(In yrs. Ia 47	st birthday) Yrs.	Months Days		Min. (Mo	e of Birth onth, Day, Yea 27, 1		rthplace (State or Foreign country)
	Director		Usual Residence of Decedent						AUG	. 41,	.936   PE	NNSYLVANIA
	nylanc how		10a. State 10b. County			Town or Lo						10d. Inside City Limits
	e Ma Se-f s	cto	MD ALLE	GANY	CU	MBERL.						1 Yes 2 □ No
	within 72 hours after death with the Maryland one. Then "neturel", or items 23e or 28e-f show the Modical Examirer: ast be notified at	Funeral Director	10e. Street and Number				10f. Zip Code	2			Citizen of What C	ountry?
	s 23e	eral	360 WILLIAMS ST	KEET	ver in H S	13	2150:		ain? (Specify Ye		U.S.A.	erican Indian
	ter dea	Fun	11. Marital Status  1	Armed Forces?		į	Was Decedent of If Yes, specify Cub			etc.)	Black, Wh	
036	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 💢 No	Specify:			Specify:	WHITE
2-0	72 hours after de "neturel", or items dical Examiner.	Completed	15. Decedent's (Specify only highest			(Give	dent's Usual Occu kind of work done	during mos	t of working		Kind of Business	
2	within lene. then.	mple	Elementary/Secondary (0-12)	College (1-4or 5-			DO NOT use retire		CD		LANDSCAF	
12	filed w Hygier other ti		12 17. Father's Name (First, Middle, L	ast)	1	MELDE	R AND LAI		'EK er's Name (First,			1110
Maryland 21215-0036	should be filed within and Mental Hygiene. s marked other then umetic event, the M	э Ве	JOSEPH CHARLES						RICIA A		•	
Z	2 should and Men is marke eumetic	ဥ	19a. Informant's Name/Relationshi			19b. Maili	ng Address (Stree	t and Numbe	er or Rural Route	Number, City	or Town, State,	Zip Code)
	nd 2 lith a 27 is r tre		SHIRLEY McCURRY	/ FRIEND		360	WILLIAMS	STRE	ET, CUM	BERLAN	D, MD 2	1502
ore,		1	20a. Method of Disposition  Burial 2 Cremation	3 Demoval from State	ce	metery, crei	osition (Name of matory or other pla		Date		Location - City o	r Town, State
Ĕ	nit. Pages artment of l ortent: if its injury or o		'4 □Donation 5 □ Other (Sp		SS.	PETE	R & PAUL	CEM.	05/24/2	006 (	CUMBERLA	ND, MD
Baltimore,	permit. Page Department o Importent: if any injury or once.		21. Signature of Funeral Service	iosness	,	23	2. Name and Addr UPCHURCH			E. P.A		
_	Q 7 € € Ø		Grendy VI	up neu	ماده دو دو دو	Do not so	ייטריא כיווני	ייוס ישואיב	יתיםים כחי	י דכוקוכה או	AND, MD	21502 Approximate
п			23a. Part1. Enter the disease, or o shock, or heart failure. List o	nly one cause on each lin	e.	O a l b	l d aa A					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	ADEN			Oft 1/1	OF	LUNK	r		ONE MONIM
п	Examiner			Due to (or as a	conseque	ence or).						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	consequ	ence of):						
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	с								
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9 X	ding I	Physician/Med	IF FEMALE:	23c. If yes, outcome of	of pregnan	ncy					23d. Date of de	alivery
Вох	atten atten i for u	cian	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	1 ☐Live birth 4 ☐ Pregnant at	2 Fetal	death 3	□Ectopic pregnand □ Other (specify) _	СУ			Month	Day Year
P.O.	the d	hysi	9 Unknown	9□Unknown								<u> </u>
	gned l		Part II. Other significant condition				- 1	_	1			to the cause of death?
rd	w requires I been signe should be	ed	HUMAN IMM	nuju Defici		7		FECTI	0,0	1 🗌 Yes	2 □ No 3/54F	Probably 4 Unknown
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<u>=</u>		Con	LIVER 1	-AILURI	<u> </u>				10	performed Yes 2	? death? No 1 ☐ Ye	
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	To the Hospital or Attending Physicien: within 24 ours after death. To the Funeral Director: After this certific completes filled in by the funeral director.	Medical Certification:	(Check only 2 Medical b	Physician: To the best of xaminer: On the basis of	examinati	vledge, deat ion and/or in	th occurred at the livestigation, in my	time, date ar opinion, dea	nd place, and due th occurred at th	e to the cause ne time, date a	(s) and manner a and place, and du	is stated. le to the cause(s)
	vithin 2 To the To the complet	Med	one) 29b. Signature and tiffe of certifier	and manner sta	ted.		29c. Licer	se number		29d. I	Date signed (Mor	nth, Day, Year)
			) Long	yout			DO	0311	8			2006
•	3		30. Name and address of person v	who completed cause of de	eath (Item	23a) (Type.	D-2-1)					
	nRS			ENAIN "	700	SETO	N DRIVE	=, CI	IMBER	LAND,	MD	21502
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		1	For State Registrer	State of Marylan			nt of H te of L		Men		iene	006	17611
			. Decedent's Name (First, Middle, Last)						2. [	Date of Deal	th	Year	3. Time of Death
Phys	ician dical		John	Loyal		Lal	lame		MA	Y <sup>oonth</sup> 28,	2006	1 Gai	0945 м
Exan			a. Facility Name (If not institution, give	street and number)		4b. City	, Town, or	Location of Deat	h		4c. Co	ounty of Death	1
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Funer	al	5.	Social Security Number 6. Sec		•		Pr 1 Year Days	If Under 24 Hrs Hours Min.		Date of Birth Month, Day,	Year)	9. Birth	place (State or Foreign intry)
Directo	or	-	215-92-2/15	M 2□F 42	Yrs.				02	/01/19	964	Mary	land
pu .		$\vdash$	Sual Residence of Decedent  Oa. State 10b. County	10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
arylan ehow	5	1	MD Allega			nberl	and						1 ☐ Yes 2 🖔 No
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vith to	ä	1	0e. Street and Number 13001 Bedford	Pood NF		101. 2	ip Code	21502		'	og. Citizer	n of What Cou USA	mtry?
be filed within 72 hours after death with the Maryland Hygiene.  Hygiene.  d other than "natural", or items 23e or 28e-f ehow event, ite Medical Examinar must be notified.	Funeral	-			0 112	Was Das				Vac as Na	14	Race - Amer	ioga Indiae
er de Item	a a	1	1. Marital Status	12. Was Decedent Ever in U Armed Forces?	.5.	was Dec If Yes, sp	ecify Cuba	spanic Origin? (S n, Mexican, Puer	o Rica	n, etc.)	14.	Black, White	
s aft	by F		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🏹 No If Yes, Give Year or Dates:		1 🗆 Yes	2 <b>∑</b> No	Specify:			Sp	pec <i>ify</i> :	White
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1 and 1 and Heelth em 27 ther to			Oa. Method of Disposition	20b. F	Place of Dispo	osition (N	ame of	-	Date			tion - City or T	
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To the Hospital or Attending Phywithin 24 hours effer death. To the Funersi Director: After this completely filled in by the funeral	Certification:		2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Af h building, etc. (Speci	ome, farm, st			163 2 0 100	28f.	Location (Si City or Town	treet and N n, State)	Number or Rui	ral Route Number,
Hospital or 24 hours effe     Funersi Dire etely filled in 8	edicai C			sicien: To the best of my knowner: On the basis of examination and manner stated.									
To the within 2 To the complet	Z		29b. Signature and title of certifier			2	9c. License	number		2	9d. Date s	igned (Month	. Day, Year)
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		-	20 Name and address of serves utility			Print)	J_J_				J	J, 200	<u> </u>
nus		1	30. Name and address of person who co William Lamm M.D.	ompleted cause of death (Itel 900 Seton D			erlan	d, Mary	and	2150	2		
	24		31. Date fifed (Month, Day, Year)	32. Registrates Sign				,					
	State strar			2006 \ Marin		do	use						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** May 14 2006 7:00 James A. McDonald /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State of Country) Wash.D.C. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1**⊠**M 2□F 70 Director 578-46-6556 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryla Department of Heelth and Mental Hygenes. Important: If Item 27 is marked other than "netural", or Items 23s or 28s-f show any injury or other traumatic event, the Madical Examination must be notified. 1 √Yes 2 No Director Camp Springs MD Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20748 U.S.A 5001 Rayburn Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 DX es 2 No 1954 If Yes, Give Year or Dates: 1963 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Procurement Administrator D.C. Public Schools 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James McDonald Sr. Isabel Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5001 Rayburn Pl.Camp Springs,Md.20748 Carol McDonald/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition X□ Burial 2 □ Cremation 3 □ Removal from State MD. 5/19/06 Vet. Cem Cheltenham, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hodges and Edwards 3910 Silver Hill RD.Suitland, Md.20746 Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute 12 tanction Ihour myocardial Physician /Medical Due to (or as a consequence of). Examiner antery COVONUVY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner ocavelial julavot The law requires thet the death certificate be executed burial-transit d intero later resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, attending physicien for use as the buria 10 years Certification; To Be Compieted by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? Year 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown euo cavcino ma Per Teucion 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed/a cevelno verser lav HICKOUY Bt 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifical
etely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 | Homicide tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai within 24 ho To the Fune completely fi 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 2006 042049 Lewmale who completed cause of death (Item 23a) (Type, Print) Name and address of person Opper Marlbors Champalou 6 MD 31. Date filed (Month, Day, Year) State JUN 05 Registrar

			For State Registrar			Marylan	•				and M		Reg.	20	06	176	16
	Dhysisi		1. Decedent's Name	e (First, Middle, La									Death	Day	Year	3. Time of	Death
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	Examir		4a. Facility Name (/	f not institution, giv	e street and numbe	r)		4b. City	, Town, or	Location of	f Death			4c. Cour	nty of Death		
: 1		#	Holy Cro	Name (First, ModRe, Last)   2. Oats of Death   Name (First, ModRe)													
	Funeral		5. Social Security N				* *					8. Date of (Month.	Birth Day, Ye		9. Birth	plece (State o	r Foreign
	Director		297-14-4	130	1UM 2EF	86	Yrs.	ivioriti is	Juys	110013					Penr	sylvar	ia
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	death with the Maryland oms 23e or 28e-f show or must be notified at	Funeral Director	10e. Street and Nur	mber				10f. Z	p Code				10g.	. Citizen d	f What Cou	ntry?	
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21215-0036	72 hc	Completed	/Snec	15. Decedent's E	ducation		16a. Dece	dent's Usi	al Occupa	ation	of working	na .	161	b. Kind of	Business/Ir	ndustry	
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7	d wil	NO.			5+		Tea	cher						Educa	ation		
g	oth vent	Be (	17. Father's Name	(First, Middle, Lasi	1)					18. Mother	r's Name	(First, Mid	dle, Mai	den Sum	ame)		
a	Menta Menta rked tlc •	To	William	H. Herkn	er					Cat	heri	ne Fr	eib	ergei	2		
Maryland	shor nd N		19a. Informant's Na	ame/Relationship	(Type, Print)		19b. Maili	ng Addres	s (Street a	and Numbe	r or Rura	l Route Nui	mber, C	ity or Tow	m, State, Zij	o Code)	
Ž	nd 2 alith a 27 le		Linda Kay	Muellen	/ Daughte	r	3606	Spru	ell D	rive,	Sil	ver S	pri	ng, I	MD 209	02	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 ie marked other than "natural", or Items 23e or 28e-f show may injury ocities the motified at any injury ocities.		20a. Method of Disp	position		20b. F	Place of Dispo	sition (Na	ime of	1			-				
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ĕ	equires sen sign ould be	Pe	Osteoporo	sis, Gas	troesopha	geal	Reflux	_Dis	ease			1	Yes	2 🛛 🗙 o	3 Prof	bably 4 🗆	Inknown
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<u>&gt;</u>	or A fiter Direction by	ŧ	4 Homicide	determined	building,	etc. (Specif	fy)	reet, racto	гу, описе		-	City or	Town, S	tate)	noer or Huri	ai Houte Num	ber,
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	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical	29a. Certifier (Check only one)	2 Medical Exa	miner: On the basis	of examina	owledge, deat ation and/or in	h occurre vestigatio	d at the tim n, in my op	ie, date and pinion, deat	d place, a th occurre	ind due to t ed at the tim	he caus le, date	e(s) and a and place	manner as s e, and due t	tated. o the cause(s	)
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2				State of Maryland / Dep NF,5/30/06,DPS,McCo Co	ertificate of D	eaith and M Death		. No. 2001	
	Physici /Medic		Decedent's Name (First, Middle, La  Ruth		Marsico		Month	2006 Year	3. Time of Death 2:20 A M
	Examin		4a. Facility Name (If not institution, given 13914 Crest Hill		4b. City, Town, or L	Spring		4c. County of Dea Montgomer	
	Funeral Director		146 09 9700	5ex 7. Age (In yrs. last birthda 1□ M 2番F 89 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y March 6,	9. Bir 1917 Ne	thplace (State or Foreign ountry) <b>w York</b>
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hyglene. Id other then "natural", or itams 23a or 28a-i ehow event, the Medical Examinat must be notified at	Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  10e. Street and Number  13914 Crest Hill  11. Marital Status  1 Never Married  2 Married  3 Widowed 4 Divorced  15. Decedent's E (Specify only highest gr  Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, Last	Lane  12. Was Decedent Ever in U.S. Armed Forces? 1	10f. Zip Code 2090.  3. Was Decedent of Hist If Yes, specify Cuban, 1 Yes 2 No cedent's Usual Occupative kind of work done du DO NOT use ratired)  Homemaker	panic Origin? (Spe , Mexican, Puerto f Specify: ion ion tring most of workin	city Yes or No-Rican, etc.)	Own Homiden Surname)	erican Indian, te, etc. <b>Thite</b> /Industry
ıya	should nd Men marke	70	Frederick Hill  19a. Informant's Name/Belationship.		iling Address (Street an			Ackerman City or Town, State,	Zip Code)
Baltimore, Ma	permit. Pages 1 and 2 should be filed wit Department of Heath and Mental Hygiend Important: If Item 27 is marked othar thu any injury or other traumatic event, tra		19a. Informant's Name/Relationship A. RULH SHEPTA  20a. Method of Disposition 1 Burial 2 Cremation 3 Department of Donation 5 Other (Special Signature of Funeral Service Line)	Daughter  ☐ Removal from State  Maryres	8 Crest Hill position (Name of rematory or other place) t Cemetery 22. Name and Address	11 Lane S 5/19, of Facility <b>Hin</b>	ilver Sp ate 20 /2006 Rates Rinal	ring, MD c. Location - City or amsey, New di Funera	20905 Town, State
	Physician /Medical		23a. Part1. Enter the disease, or con shock, or beart failure. List only Immediate Cause (Final disease or condition resulting in death)	pplications that caused the death. Do not e					Approximate Interval Between Onset and Death  I Week
58/60,	/Medical Examiner	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. End Stage Dement Due to (or se a consequence of):  c Due to (or as a consequence of):  d	ia				6 Years
O. Box	The law requires that the death certific te hes been signed by the attending F vage 2 should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		B Ectopic pregnancy Discrete (Specify)			23d. Date of de Month	livery Day Year
rds, P	quires that n signed b uld be deta	ρ	Part II. Other significant conditions  Cerebrovasceul	contributing to death but not resulting in the ar Accident	underlying cause given	in Part I.			o the cause of death?
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	ysiclen: Th nis certificete director, pag	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpati	Other	26. Place of Death		ce 6 □Other (Spe	wift)
DIVISION OF	tending Pl death. tor: After th	Certification; T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year)  28b. Time Injury 28c. Place of Injury - At home, farm,	of 28c. Injury a Work?  M 1 □ Ye	at 2 es 2 🗆 No	8d. Describe how	injury occurred	
ō	o the Hospital or Al ithin 24 hours after o o the Funeral Direc ompletely filled in by		29a. Certifying P	building, etc. (Specify)  hysician: To the best of my knowledge, de	ath occurred at the time	, date and place, a	and due to the caus	se(s) and manner as	s stated.
•	To the Hospital within 24 hours a To the Funaral I sompletely filled	Medical	29b. Signature and title of certifier	miner: On the basis of examination and/or and marrier stated.	29c. License to	nion, death occurre	ed at the time, date	and place, and due	e to the cause(s)
龄	Sta Registi		30. Same find address 1 person who are filled (Month, Day, Year) 8	com, leted cause of death (Item 23a) (Typ	e, Print) afwood Dr	ive; Suit	e205 j Si	TverSprin	9, MD 2090/

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	/Medic Examin		4a. Facility Name (If not institution	n, give street and numi	ber)				Location o		<u></u>	4c. Co	unty of Death	1 45 1	
П		Щ	Brookfield Man		t Care	hirthdou)	If Under 1		dlebu If Under 2	_	8. Date of Birth			roll place (State or	Fossian
	Funeral Director		5. Social Security Number 434-40-0844	18 M 2□F	78	Yrs.		Days	Hours	Min.	May 13,	1928	Cou	siana	roreign
pue	A 18		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	cation							10d. Inside City	Limits
M	a-f show	tor	MD Carro	11	New	Wind	sor							1 ☐ Yes	2 🔀 No
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P of Plan	h and Mental Hygiene. 7 is marked other than traumatic event, tre Wes	To Be	Thomas L. Morr						_		(First, Middle, I nsend	Maiden Sui	mame)		
( Page 1	perint. Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Once.		19a. Informant's Name/Relation								l Route Number			o Code)	
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5	ector, Atter this certificate his by the funeral director, page	$ \mathbf{r}_{i} $	27. Manner of Death  1 Satural 5 ☐ Pend	28a. Date of		b. Time of Injury		Bc. Injury Work		2	28d. Describe ho		Other (Speci courred	ny)	7
	within 24 hours after death.  To the Funeral Director; A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could	mined 286. Place	of Injury - At home g, etc. (Specify)	, farm, str	reet, factory,	office		2	28f. Location (St City or Town	reet and N n, State)	umber or Rur	al Route Numb	⊕ <i>f</i> ,
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	Withi To 11	×	29b. Signature and title of certific	er			29c.	License	number	~	2	9d. Date si	gned (Month,	Day, Year)	
h- ^	WJL		J. Fit	Larico	se N	10	]	101	000	746	36	05	1 111.	7500	)
	10		30. Name and address of person	wno completed cause	or death (Item 23	(Type.	Rez J	low	Im	4.	Unis	W.B	lida	Md. 2	17131
	Sta Registi		31. Date filed (Month, Day, Yea, MAY 1	9 2006 32. 8	gistrar's Signature	K /	Cast !	,				- 4	7		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 005 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 11:58 p<sub>M</sub> **Physician** Joseph Clayton Manger, Jr. 14, 2006 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll 509 Uniontown Road Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Jul 19, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1923 t**∑** M 2 ☐ F Maryland 217-16-2431 82 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 28a-f ehow injury or other traumatic event, the Medical Examinar must be notified at Westminster 1 ☐ Yes 2√2 No Maryland Carroll Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 509 Uniontown Road 21158 USA 238 Funeral Iteme 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ∰Yes 2 □ No If Yes, Give WWII Year or Dates; WWII 1 ☐ Never Married 2 ☑ Married ٥ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: white þ 3 Widowed 4 Divorced natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "or any Injury or other traumatic event, the Media Elementary/Secondary (0-12) College (1-4or 5+) Clothing Company Mechanic/Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph C. Manger, Sr. Rosalie Awalt ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis T. Manger, wife 509 Uniontown Road, Westminster, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 05/18/2006 Kriders Cemetery Westminster, MD 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home M01-191 91 Willis Street, Westminster, MD 21157 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Y-3 Copyestive 10 /Medical Due to (or as a consequence of): Examiner Coronar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit that initiated events resulting in death) Last and The law requires that the death certificate be exec Due to (or as a consequence of) sate has been signed by the attending physician page 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE . If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed 1 Yes 2 No the Hospitel or Attending Physician: nerel Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funerel C

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D46387 30. Name and andress of person who compared cause of death (Item 23a) (Type, Print) batis Baltimore MARYAND abid Street 7155, SHUC Caroline 32. Segistrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAY 17 2006

State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 #8, per f.home, 5/22/06, Certificate of Death E.T, WCHD Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month 10:46 A<sup>M</sup> Yolanda Helen Musselwhite 5 19 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ocean City
If Under 1 Year | If Under 24 Hrs. |
Months Days Hours Min. 12537 Creek Dr. Worcester 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9/4/1915 Birthplace (State or Foreign (Month, Day, Vear) / 1915 Country) **Funeral** Days 1 ☐ M 2 🖸 F 90 Director 242-05-3447 NY Usual Residence of Decedent 10c. City, Town or Location 10d. tnside City Limits 10b. County r then "natural", or items 23a or 28a-f ehow the Modical Examinar must be notified at 1 Yes 2 No Director MD Ocean City Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12537 Creek Dr. 21842 USA death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H Is marked ot Nicholas Takosh Anna Dudlak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 la,
eny injury or other trau 12537 Creek Dr., Ocean City, MD 21842 Barbara Hood Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State Cape Henlopen Crem. 5/23/2006 4 ☐ Donation 5 ☐ Other (Specify) Frankford, DE 21. Signature of Tunor I Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 Lungar Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MENOSCIEDONC CAMOIONASCULARE DISOSPICE Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of). Examiner Esqueritally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine -transit death certificate be executed and Due to (or as a consequence of): physician a s the burial-Box 68760, ician/Medical IF FEMALE: 980 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the P.0. Physi 9 Unknown 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, δ 3 Probably 4 □Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? 26. Place of Death Check only of Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After Certification: Division or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D46257 J-22-06 30. Name and address of person who completed cause of death (Item 23a) (Type. Print) on ocemncy Bevo, Berlin, Mill Enwin CASMENA, MD (CENT ON OCEMNCIA BENU, BERLIN, MI) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month 9:45 EVELYN L. MALCOLM A M MAY 2006 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death HOWARD ELTERNHAUS ASSISTED LIVING DAYTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days Months Hours 1 ☐ M 2 🖾 F VIRGINIA APRIL 20, 1921 577-20-1906 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No MARYLAND MONTGOMERY SILVER SPRING 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number IISA 2800 OLD BRIGGS CHANEY ROAD 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: WHITE 1 ☐ Yes 2 No Specify: 3 Midowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ROY S. CROSS MARGARET ARMSTRONG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JOAN GARDNER - DAUGHTER 2800 OLD BRIGGS CHANEY ROAD, SILVER SPRING, MD 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State BRENTWOOD, MD FORT LINCOLN CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 05/22/2006 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC., 21. Signature of Funeral Service License 11800 NEW HAMPSHIRE AVE., SILVER SPRING, MD 20904 23a. Part1. Enter the disease, or complications that causes shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

rai', or iteme 23a or 28a-f show Examiner must be notified at

Director

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: If item 27 is marked other then "natural", or iteme 23s or 28s=f show

permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natureny injury or other treumatic event, the Medical once.

Baltimore, Maryland 21215-0036

anding physicien and use as the burial-transit atten for u ed by the a ate has been significated be page 2 should be this After after death.
Director: Aff completely filled in by

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	disease or condition resulting in death)	a. MITHER'S disease	
	Tesultary in death)	Due to (or as a consequence of):	
miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. — Dee to (or as a consequence of).	ON EXAMINER
dical Exa	resulting in death) Last	Due to (or as a consequence of):  _ d.	APPROVED BY MEDICAL EXAMINER
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 \( \) Live birth \( 2 \) Fetal death 4 \( \) Pregnant at time of death 9 \( \) Unknown \( \) Unknown	23d. Date of delivery  Month Day Year
ed by Pt	Part II. Other significant conditions of	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2
Complet			24a. Was an autopsy performed?  1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
Be (	25. Was case referred to medical examiner?		(Check only one)
10	1 Yes 2 No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Ho	me 5 Residence 6 Other (Specify)
ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio	(Month, Day Year) Injury Work?	28d. Describe how injury occurred Subject fell
Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State) HZOL LINTHICUM Pd MD
Medical (	29a. Certifier (Check only one)	nysician. To the best of my knowledge, death decembed at the time, data and place, miner: On the basis of examination and/or investigation, in my opinion, death occurr and manner stated.	red at the time, date and place, and due to the cause(s)
Σ	29b. Signature and title of certifier	Terma MD 29c. License number Di4V448	29d. Date signed (Month, Pay, Year)  5/18/06
	30. Name and address of person who Ari M. Lieman M	completed cause of death (Item 23a) (Type, Print) ND, 7070 Samual Mose Dr. Columbia,	md 2/045

Registrar

within 24 hours a To the Funerel C

State

31. Date filed (Month, Day, Year)

MAY 1

32. Registrar's Signature

2006

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	OW Road  Sex 1 M 2 F  7. Ag  W Road  12. Was Decedent Amed Forces? 1 M Yes 2 If Yes, Give Year or Dates:  Education rade completed)  College (1-4or \$  st)  (Type, Print)  Fe	16a. Dece (Give life)  19b. Mail  19b. Mail  20b. Place of Disp. cemetary, cre	Prince F  If Under 1 Year Months Days  ocation  rederick  10f. Zip Code 20678  Was Decedent of H If Yes, specify Cuba  1 Yes 2 No edent's Usual Occupe e kind of work done of DO NOT use refired.  ty guard/ ling Address (Street Mac's Hol	r Location of Death Prederick If Under 24 Hrs. Hours Min.  Bispanic Origin? (Span, Mexican, Puerto Specify:  Pation during most of work of the Month	ecfly Yes or No-Rican, etc.)  ing  phter e (First, Middle, Mardesty al Route Number, Prince F	Day People People Ac. County of Death Calvert  Year) 1923  9. Birthp Cour Mary  1923  9. Birthp Cour Mary  11. Race - Americ Black, White, Specify: whi  16b. Kind of Business/In Dept. of Deced Government Maiden Sumame)  City or Town, State, Zip Frederick Mi	10d. Inside City Limit 1   Yes 2   2   2   2   2   2   2   2   2   2
a. Facility Name (If not institution, gi 6074 Mac's Holl . Social Security Number 6. 213-22-0626  Jual Residence of Decedent 10a. State 10b. County  Maryland Calvert 10e. Street and Number 6074 Mac's Hollc 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest gi Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last Joseph May 19a. Informant's Name/Relationship Betty L. May —wi 20a. Method of Disposition 1 Marrial 2 Cremation 3 4 Donation 5 Other (Specify Ports)	OW Road  Sex 1 M 2 F 7. Ag  To Road  12. Was Decedent Armed Forces? 1 M 2 M 2 M 1 M 1 M 1 M 1 M 1 M 1 M 1 M	82 Yrs.  10c. City, Town or Lo  Prince F.  Ever in U.S. 13.  No  44–46  16a. Dece (Give life)  5+)  Securi  19b. Maili  6074  20b. Place of Dispendency, cre	Prince F  If Under 1 Year Months Days  Ocation  Prederick  10f. Zip Code  20678  Was Decedent of H If Yes, specify Cube to Work done of DO NOT use retired  Ly guard/  Img Address (Street  Mac's Hole  Dosition (Name of	r Location of Death Prederick If Under 24 Hrs. Hours Min.  Bispanic Origin? (Span, Mexican, Puerto Specify:  Pation during most of work of the Month	8. Date of Birth (Month, Day, Sept. 14  10  ecfty Yes or No- Rican, etc.)  ing  phter e (First, Middle, Mardesty al Route Number, Prince F	Ac. County of Death Calvert  9. Birthp Court  1923 Mary  1923 Mary  109. Citizen of What Court  14. Race - Amenic Black, White, Specify: whi  16b. Kind of Business/In Dept. of De Ted Government Maiden Sumame)  City or Town, State, Zip	place (State or Forentry)  land  10d. Inside City Limity?  escan Indian, etc.  te  idustry  fense ent
6074 Mac's Holl  3. Social Security Number 6. 213-22-0626  Jaual Residence of Decedent 10a. State 10b. County  Calvert 10e. Street and Number 6074 Mac's Hollo 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last  Joseph May 19a. Informant's Name/Relationship Betty L. May —wi 20a. Method of Disposition 1 Marrial 2 Cremation 3 4 Donation 5 Other (Specify Part 1)	OW Road  Sex 1 M 2 F 7. Ag  To Road  12. Was Decedent Armed Forces? 1 M 2 M 2 M 1 M 1 M 1 M 1 M 1 M 1 M 1 M	82 Yrs.  10c. City, Town or Lo  Prince F.  Ever in U.S. 13.  No  44–46  16a. Dece (Give life)  5+)  Securi  19b. Maili  6074  20b. Place of Dispendency, cre	Prince F  If Under 1 Year Months Days  Ocation  Prederick  10f. Zip Code  20678  Was Decedent of H If Yes, specify Cube to Work done of DO NOT use retired  Ly guard/  Img Address (Street  Mac's Hole  Dosition (Name of	If Under 24 Hrs. Hours Min.  Bispanic Origin? (Span, Mexican, Puerto Specify:  Batton during most of work at 1)  Fire fice 18. Mother's Nam  Lydia Fand Number or Rur. Low Road	ecfty Yes or No- Rican, etc.)  ing  phter e (First, Middle, Mardesty al Route Number, Prince F	Calvert  9. Birthp Cour 1923  9. Birthp Cour Mary.  1923  Og. Citizen of What Cour Inited State 14. Race - Americ Black, White, Specify: whi 16b. Kind of Business/In Dept. of De Ted Government Aciden Sumame)  City or Town, State, Zip Frederick M	Iand  Iod. Inside City Limit 1   Yes 2   1/2   2   1/2
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21. Signature of Funeral Service Lic	enseq		Cemetery M	ce)		20c. Location - City or To Barstow Mar	
	och					eral Home : Republic MD	
Sequentially list conditions, if any, leading to immediate cause. Ener unidentying Cause (Disease or injury that initiated events resulting in death) Last	bDue to (or as	a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth	2 Fetal death 3		у		23d. Date of deliv Month	rery Day Year
	s contributing to death t	but not resulting in the	underlying cause giv	ven in Part I.			the cause of death bably 4 DUnkr
Diabetes					autops	ned? prior to co	opsy findings avai
25. Was case referred to medical				26. Place of Dea		X	20110
examiner? 1 ☐ Yes 2 🔀 No	-		ent 3LI DOA	4 🗀 Nursing n			ify)
27. Manner of Death  1   Natural 5  Pending 2  Accident investigat	(Month, Da	ay Year) 28b. Time Injury			28d. Describe no	ow injury occurred	
3 Suicide 6 Could no 4 Homicide determine	ed 200. Flace Util		street, factory, office				ral Route Number,
29a. Certifier (Check only one)  1 Certifying 2 Medical Ex	caminer: On the basis	of examination and/or i	ath occurred at the ti investigation, in my	me, date and place opinion, death occu	, and due to the carred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
29b. Signature and title of certifier	1 1 1	). ,			2	-	
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Siff CCtt	resulting in death)  Sequentially list conditions, fany, leading to immediate ause (Disease or injury hat initiated events esuiting in death) Last  FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II, Other significant conditions:  COPD  Diabetes  25. Was case referred to medical examiner? 1   Yes 2   No   27. Manner of Death 1   Matural   5   Pending   2   Accident   3   Suicide   4   Homicide   4   Homicide   5   Medical Examiner   2   Medical Examiner   2   Medical Examiner   3   Suicide   4   Homicide   4   Homicide   4   Medical Examiner   2   Medical Examiner   3   Suicide   4   Homicide   4   Medical Examiner   4   Medical Examiner   4   Medical Examiner   5   Medical Examiner	Blad Due to (or as a lisease or condition resulting in death)  Sequentially list conditions, fany, leading to immediate ause (Disease or injury hat initiated events esulting in death) Last  FFEMALE:  23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions contributing to death in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions contributing to death in the past 12 months?  25c. If yes, outcome 12   Pergnant a 9   Unknown  27d. Manner of Death   Who part   Pergnant a 12   Pergnant a 13   Pate filed (Month, Day Year)  28a. Date of Injury (Month, Day Year)  29b. Signature and title of certifier  30. Name and address of person who completed cause of Joseph J. Barth MD Hospit 31   Date filed (Month, Day Year)  32   Pate filed (Month, Day Year)  33   Pate filed (Month, Day Year)  34   Pate filed (Month, Day Year)  35   Pents   Person   Part   Person   Pents   P	A. Blacker Cancer Due to (or as a consequence of):  Brequentially list conditions, fany, leading to immediate ause. Enter Uniderlying Lause (Disease or injury hat initiated events esulting in death) Last  FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions contributing to death but not resulting in the COPD  Diabetes  25. Was case referred to medical examiner? 1   Yes 2   Xho  27. Manner of Death 1   Xhatural   5   Pending investigation   28a. Date of Injury (Month, Day Year)   28b. Time Injury (Month, Day Year)   28b. Time Injury (Check only one)   29b. Signature and title of certifier  29b. Signature and title of certifier  Joseph J. Barth MD Hospital Rd. Pr. 24   Date liber (Month, Day Year)   32   Registrals Signature	Bladder Cancer  Due to (or as a consequence of):  Due to (or as a conseque	Bladder Cancer  Due to (or as a consequence of):  Bequentially list conditions, starly leading to immediate ausse. Ener funders ying ausse. Disease or injury hat initiated events esuiting in death) Last  FEMALE:  23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  COPP  Diabetes  25. Was case referred to medical evarament? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  COPP  Diabetes  26. Place of Death   Work?   28b. Time of   Work?   28b. Time of   Work?   1   Yes 2   No   28b. Time of   Work?   1   Yes 2   No   28b. Discovery   1   Yes 2   No   1	Bladder Cancer	Bladder Cancer  Due to (or as a consequence of):  Due to (or as a conseque

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dale of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2006 4:13 P M May 14, Roberta Cherry McConnell /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 3939 Sea Side Court Apt 203 Calvert County North Beach 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days 79 1 ☐ M 2 🔀 F 577-34-1577 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County worle ! r then "natural", or Items 23a or 28a-f ehov the Modical Examinar must be notified at 1X Yes 2 □ No Director MD Calvert North Beach 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3939 Sea Side Court Apt 203 20714 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: à 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. other then "r Elementary/Secondary (0-12) College (1-4or 5+) 12 Teacher's Aide Calvert Co. Bd of Ed 12 should be filed w h and Mental Hygier 7 Is marked other th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Cherry Ruth Leavitt Ellsworth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 I e n eny Injury or other treun 3610 Kings Drive Dunkirk, MD George McConnell (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 22. 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem 4 ☐ Donation 5 ☐ Other (Specify) 2006 Cheltenham, MD 21. Signature of Funeral procedicen 22. Name and Address of Facility Lee Funeral Home Calvert, PA Michael W. 8125 Southern Maryland Blvd. Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Luna -t1/a cal /Medical Due to (or as a consequence of): **Examiner** CAD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit death certificate be executed COPD Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Dale of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown certificate has been signed by rector, page 2 should be detact Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Anemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 170 24a. Was an autopsy performed? 1 Yes 2 No or Attending Physician: After this certification funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ LNG 1 Inpatient 2 ER/Outpatien 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours after To the Funerel Dire t 🗹 Carrilying Physician: To the best of my knowledge, Scath occurred at the time, Sate and Jenn, and due to the newsets) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date, signed (Month, Day, Year) 29b. Signature and title of certifier Sho D 50290 5/15/06 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Fred MO 110 Shal HOSP RD 32. Registra Signature 31. Date filed (Month, Day, Year) State MAY 1 8 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Wanda Albina Marsteller May 15, 2006 2:15 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oak Lodge Home Assisted Living Pasadena Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours Min 1 M 200 F 84 Director 212-12-1400 Aug. 13, 1921 MD Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. fnside City Limits 10b. County me 23a or 28a-f ehow 1 ☐ Yes 21 No Pasadena Anne Arundel Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7753 Outing Avenue 21122 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. rithen "natural", or Iteme 11. Maritaf Status 1 □ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Albin Lechowicz Kasmira (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leanne Monica Cullember/Daughter 634 Emerson Pl. Severna Park, MD 21146 May 19, 2006 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 tment of t rtant: If It nlury or r 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment i Important: If any injury or once. Glen Haven Cemetery Glen Burnie, MD 4 □ Donation 5 □ Other (Specify) Signature of Funeral Service Licensee Rarranco & Sons, P.A. 495 Gov. Ritchie Hwy. P.A. Severna Park Funeral Home Hwy. Severna Park, MD 21146 23a Part 1. Enter the disease, shock, or heart failure. L complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between VA Onset and Deag Immediate Cause (Final disease or condition resulting in death) **Physician** we /Medical Due to (or as a consequence of): Examiner (BRILLA RIAC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine nding physicien and use as the burial-transit The taw requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant etter for u 3 Ectopic pregnancy in the past 12 months?
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9 ☐ Unknown Month 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part f. þ 4 Unknown 1 Yes 2 No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 20 No certificate 2 No 1 ☐ Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28t. Location (Street and Number or Rural Route Number. City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide

Division of Vital Records, P.O. Box 68760, neral Director: / within 24 hours a

29b. Signature and title of certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

ted cause of death (Item 23a) (Type, Print) M

31. Date filed (Month

29a. Certifier

Medical

State Registrar degistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Vera 447 AM 1191210 Ker 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Washington Washington Co. Hospital Hagerstown 9. Birthplace (State or Foreign 1918 MD 8. Date of Birth (Month, Day, Year) Jan • 27, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🖫 F 218-50-3060 88 Director Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-1 show the Medical Examinar must be notified at Hagerstown Washington 1X Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1140 Luther Dr. 21740 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 24 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3€NVidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygient Important: if Item 27 is marked other that any njury or other traumatic event, that once. homemaker 12 own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roy Robinson Charlotte Clark ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co2)1742 19a. Informant's Name/Relationship (Type, Print) Stacey Norbeck(Granddaughter)19109 Longmeadow Rd., Hagerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XIXBurian 2 □ Cremation 3 □ Removal from State Boonsboro Cemetery5/20/06 Boonsboro, MD 4 □ Donation 5 □ Other (Specify) 21 Signature of Fun all Service Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD 21769 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Heart failure **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Division of Vital Records, P.O. Box 68760. Physician/Medical attending I IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

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06-03669 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Michael Bruce Neibert 1- For State Certificate of Death Reg No. Registrar I. Decedent's Name (First, Middle,Last) 2. Date of Death 3 Time of Death Physician/ Month Year 2214 hrs Michael Bruce Neibert May 29, 2006 Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (if not institution, give street and number) Washington Smithburg Route 64 & Route 419 If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or 5. Social Security Number 7. Age (In yrs last birthday) **Funeral** Months Days Hours 08/10/1986 MD Director 19 200-66-2044 Country) 1 XM Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location Yes 2 X No Waynesboro PA Franklin 28a-f show marked other than "natural", or items 23a or 28a-f shove event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 7353 Iron Bridge Road 17268 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. Armed Forces? White etc 1 XXNever Married 2 Married 1 Yes Divorced If Yes, Give Year Specify White 3 Widowed 4 1 Yes 2 X No specify: 2 16a Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) es I and 2 should be filed within 72 to of Health and Mental Hygiene. MD 21215-0036 12 Equipment operator Excavating 18.Mother's Name (First, Middle, Maiden Surname) 17. Fatner's Name (First, Middle, Last) traumatic event, the Bruce I. Neibert, Jr. Anne M. Baltozer Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) ၉ 7353 Iron Bridge Rd. Waynesboro, PA 17268 Bruce I. Neibert, Jr. father item 27 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a, Method of Disposition crematory or other place) 1 XBurial 2 Cremation 3 X Removal from State permit Pages
Department of
Important: I Green Hill Cemetery 06/02/2005 Wavnesboro, PA Donation 5 Other Specify: 22 Name and Address of Facility Grove-Bowersox Funeral Home, Inc 21. Signature of Funeral Service Licensee anette. 50 S. Broad St. Waynesboro, PA 17268 100cl Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical AMENDED UNPENDED physician the burial -Box 68760 23d. Date of delivery 23c If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify, 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e Did tobacco use contribute to the cause of death? o ş Yes 2 ✓ No 3 Probably 4 Unknown ۵. Completed of Vital Records, 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of performed? death? 2 No ✓ Yes 2 No 1 🗸 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 Other<sub>4</sub> ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes 70 28c, Injury at Work? 28a Date of Injury 28d Describe how injury occurred 27 Manner of Death 28h Time of Injury Certification: To the Hospital or Attending May 29, 2006 Driver of auto struck a fixed object Natural 2200 hrs 1 Yes 2 V No Division Pending hours after death 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) Rt 64 & Rt 419, Smithburg, MD determined (Specify) Local Street Fo the Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. May 30, 2006 mis 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month Way) Year 32 Registrar's Signatut 2006 State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 16 8:00 A M NICHOLSON MAY 2006 STANLEY L. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner MONTGOMERY 17700 WHITE GROUND ROAD BOYDS If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours 1 ☑ M 2 ☐ F 74 June Maryland 214-28-2394 Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Boyds Md. Montgomery Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20841 United States 17700 White Ground Road by Funeral 14. Race · American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1∑Yes 2□No 1947-If Yes, Give Year or Dates: 1949 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) County Government Truck Driver 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) William Meredith Nicholson Annie Ellis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17700 White Ground Road, Boyds, Md. Dorothy M. Nicholson / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If ite 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/20/06 Beallsville, Md. Monocacy Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home munil H Box 5038, Laytonsville, 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC non SMARL CELL LUNG MONTHS **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical as attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. I the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contribute to the cause of death? Division of Vital Records, pe 1 TYes 2 No 3 Probably 4 Unknown should t Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has performe certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 1/Q Natural 2 ☐ Accident 5 Pending To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MAU/ 16,2006 242452 30. Name and address of p \* on who completed cause of death (Item 23a) (Type, Print) DX CH ITRA PHKIP # 327, OCNEY, MD PRINCE BRIVE 32. Abgistrar's Signature 31. Date filed (Month, Day, Year) 18 2006 Registrar

			For State Registrar	State of Maryland		artment of Hetificate of L			iene g. No.2006	17631
	-4		Decedent's Name (First, Middle, La	st)		<del></del>		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic	_	Amelia Chris	tina Noppenb	erger			May	19, 2006	1:57 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution, giv			4b. City, Town, or		th	4c. County of Dea	
			Frederick Memo				erick		Freder	
	Funeral Director		220-20-0032	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		9. Bii 928 Mar	thplace (State or Foreign ountry) yland
	and	}	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Manyl faho	٥	Maryland Carroll	We	Airy					1 Stes 2 No
	the 28a-	rec	Maryland   Carroll  10e. Street and Number	nt.	AILY	10f. Zip Code		10	og. Citizen of What C	ountry?
	3a of	ā	1007 Parade Lane			21771			U.S.A.	
	death ms 2	Funeral Directo	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. \	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (S	Specify Yes or No-	14. Race - Am	
ထ္	after or Ite	Fu	1 ☐ Never Married 2 ☐ Marned	1 Yes 21 No		Yes 21 No	Specify:	no mozn, etc./	Black, Whi	
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7	withir ane. than	m d m	Elementary/Secondary (0-12)	College (1-4or 5+)	Baker	)			Food serv	vice
g 7	filed Hygi other	ပိ	17. Father's Name (First, Middle, Last,				18. Mother's Na	me (First, Middle, N		
lan	uld be Nental rked c	To Be	Michael Kropp				Margar	et Makosk	a	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Menial Hygiene. Department of Heath and Menial Hygiene. Important: I flem 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Modical Examiner mant be notified at once.		19a. Informant's Name/Relationship ( Denise Sturm - da	The state of the s					City or Town, State, Marylane	
Baltimore,	ges 1 and 2. It of Health al If item 27 Is or other trau	·	20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐	CG CG	metery, crer	sition (Name of natory or other place			20c. Location - City or	
ţ	t. Pa rtmen rtant: njury	ř	4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Cice			Faith 1 . Name and Addres		the state of the s	altimore,	
Ba	Depa Impo any in		sherow Can	ulle Glu	ce 8	E. Ridgev	ville Bo	ulevard,	uneral Ho Mt. Airy,	
g. I	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Finat disease or condition	one cause on each line.		er the mode of dying	g, such as cardia	ic or respiratory arre	st,	Approximate finterval Between Onset and Death
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39 ×	entifica ling ph	Med	IF FEMALE:	222 #						
Вох	eath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. ff yes, outcome of pregnar  1 Live birth 2 Fetal  4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	fivery Day Year
P.O.	res that the de igned by the a be detached f	iysic	1 ☐ Yes 2 ☑No 9 ☐ Unknown	9 Unknown	- SE	Other (specify)				
<u> </u>	s that ned b s deta	by Pt	Part II. Other significant conditions	contributing to death but not resu	Iting in the u	nderlying cause give	n in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
rds	w require been sig should b	ed b						1 ☐ Ye	s 2 1 No 3 □ P	robabfy 4 □Unknown
900	awre as bec 2 sho	Completed						24a. Was ar	24b. Were a	utopsy findings available
Ě	The ste had page	mo.						perform	ned? death? □ No 1 □ Yes	completion of cause of
ita	Physicien: rthis certific ral director,	Be (	25. Was case referred to medical examiner?					eath (Check only one	9)	
Ž	hyeid his ca al dire	ဥ	1 ☐ Yes 2 ☑ No		ER/Outpatien		4   Norsing I		nce 6 Other (Spe	ecify)
n o	ing P	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	(Month, Day Year)	28b. Time of Injury	Work		28d. Describe ho	w infury occurred	
sic	Attending r death. ector: After by the fune	icat	2 ☐ Accident Investigatio	B GGs Diago of Laive. At he	me farm etc		′es 2 □No	28f Location (Str	eet and Number or A	Jumi Pouto Numbos
Division of Vital Records,	lor A efter Direc	Certification;	4 Homicide determined	building, etc. (Specify	)	eet, ractory, office		City or Town		urar Houle (vumber,
_	To the Hospital or Attending Physicien: The law within 24 bours effer death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.		29a. Certifier 1 ✓ Certifying PI	nysicien: To the best of my know	vledge, death	occurred at the tim	e, date and plac	e, and due to the ca	use(s) and manner a	s stated.
	ne Ho	edical	(Check only 2 Medicel Examone)	miner: On the basis of examinate and manner stated.	ion and/or inv	estigation, in my op	inion, death occ	urred at the time, da	te and place, and du	e to the cause(s)
	To th withir To th comp	×	29b. Signature and title of certifier			29c. License			d. Date signed (Mon	
	. \		Sillunon	M.D.		00	105579	5	5   21	06
	H		30. Name and address of person who				Momoria	1 Hospital		
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 3 2	32. Registrar's Signat	# A	and .				

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Will

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liams A. Ogunse	itan State of Maryland / Depa	rtment of Health and Mental I	Hygiene			
	1- For State Cer	tificate of Death	Reg No.	200	1769	3 6
Physician/	Decedent's Name (First, Middle,Last)		Date of Death     Month Day	Year	or time of Bodin	1 6
dical Examiner	Williams Agboola Ogunseitan		May 25, 2006	1001	1442 hrs	
	A. E. Hill. Name (if not institution also street and pumper)	4b. City. Town, or Location of Dea	oth 4c	County of Death		1

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Physician/	-
Medical Examiner	
and the second	4

**Funeral** Director

death with the Maryland

28a-f show items 23a or 0. Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", on injury or other traumatic event, the Medical Examiner.

Important: injury or oth Physician /Medical Examiner

and P.O. Box 68760, Division of Vital Records, To the Hospital or Attending Physician: this within 24 hours after death.

To the Funeral Director: the

 Facility Name (if not institution, give street and number) Prince George's Lanham 9331 Lanham Severn Road If Under 1 Year | If Under 24Hrs 8. Date of Birth (MM/DD/YYYY Social Security Number 6 Sex 7 Age (In yrs\_last birthday) Months Days Hours July 24, 1950 55 CountryNigeria 216-29-1695  $_{1}X_{M}$ 2 Usual Residence of Deceden 10d. Inside City Limits 10c City, Town or Location 10b. County Yes 2 X No Prince George's Lanham Maryland Director 10f. Zip Code 10g Citizen of What Country? 10e. Street and Number 20706 Nigeria 9331 Lanham Severn Road Funeral 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14 Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Married 2 X No Yes 4 X Divorced 3 Widowed f Yes, Give Year 1 Yes 2 X No specify: Specify Black à 16a Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Taxi Driver Transportation 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Beatrice Be Joseph Ogunseitan (Unavailable) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ပ 19a Informant's Name/Relationship (Type, Print Lylinder Christiana Gbadamosi/ 23131 N. Waterlake Dr., Richmond, TX 77469 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 1 X Burial 2 Cremation 3 X Removal from State crematory or other place) 6/10/06 Ibadan, Nigeria Donation 5 Other Specify Apata Ranch 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Thibadeau Mortuary Service, P.A. M00956 933 Gist Ave. LL. Silver Spring, MD the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart M00956 20910 Approximate Interval Between Onset and failure. List only one cause on each line Death Complications of leg injury Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last /sician/Medical XUNPENDED **AMENDED** item#23a,27,28a-f,perME,G856,6/8/06 TT 23d Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify, Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? 1 🗸 Yes ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medica Be Other<sub>4</sub> examiner? DOA Nursing Home 5 Residence 6 V Other Scene Inpatient 2 FR/Outpatient 3 1 🗸 Yes မ 28a Date of Injury (Month, Day, Yea 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred 27 Manner of Death Natura Pending 1XX Yes 2 No deceased was assaulted 4/20/2006 lunk Accident 28f. Location (Street and Number of Rural Route Number, City or Town, State) 4201 Fillin Road 1 and Very, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. Suicide determined (Specify) New Carrollton Metro station 4 X Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. May 26, 2006 30. Name and address of person who completed e of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31 Date filed (Month Day, Year) Registrar's Signat State Rose 2006 Registra

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			For State Registrar	State of Maryla		artment of H rtificate of I			Re	g. No.	006	176	33
E. S. P.	Physicia	- 51	Decedent's Name (First, Middle, Last)	DENNIS LEE	PRETTYM	AN			Date of Deatl Month MAY 1		6 Year	3. Time of D	
	/Medic Examin		4a. Facility Name (If not institution, give s		R	4b. City, Town, or BETH		Death		1	ty of Death		
	Funeral Director			7. Age (In yr	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min.	Date of Birth (Month, Day, c 18,		Con	nplace (State or I untry) higan	Foreign
	Maryland a-f show	tor	Usual Residence of Decedent  10a. State  10b. County  Virginia Fairfax		City, Town or Lo	ocation						10d. Inside City 1 ☐ Yes 2	
	with the	Direc	10e. Street and Number 4214 Penner Lane			10f. Zip Code 22033				og. Citizen o Unite		-	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If term 27 is marked other than "natural", or itema 23a or 28a-f show any injury of other traumatic event, the Madical Examinar must be notified at once.	by Funeral Director		12. Was Decedent Ever in Armed Forces?  1	62-	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origir n, Mexican, I Specify:	n? (Specify Puerto Rica		14. Pa		ncan Indian, e, etc.	
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and 21	d be filed w ental Hygier ked other ti ic event, In	To Be Co	17. Father's Name (First, Middle, Last) Emanuel H. Prettym	an 2	Commi	unication	18. Mother's	s Name (F	t rst, Middle, M avican			Force	
lary	2 shoul and Me Is mari		19a. Informant's Name/Relationship <i>(Ty</i> JoAnn Prettyman, wi	pe, Print)		ng Address (Street a	and Number	or Rural R	oute Number,	City or Tow		ip Code)	
Baltimore, Maryland	ages 1 and nt of Health i: If item 27		20a. Method of Disposition  1X Burial 20 Cremation 3X R	20b	D. Place of Disposers, cre	osition (Name of matory or other place Nat'1 Ce	Θ)	Date	2	22030 20c. Location	- City or		
Baltin	permit. Pa Departme Important any injury		4 □ Donation   5 □ Other (Specify)  21. Signal are of Funeral Service Licen	1	2	2. Name and Address 0565 Main	ss of Facility	Ever	ly Fun	eral H		VA	
*	Physician /Medical Examiner	ər	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons	REATITI sequence of):		g, such as ca	ardiac or re	spiratory arre	est,		Approximate Interval Betwee Onset and De	
,8760,	The law requires that the death certificate be executed site has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of):								
P.O. Box 6	es that the death certific igned by the attending p be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preduction of the second of the se	etal death 3	□Ectopic pregnancy □ Other (specify)				T .	Date of deli Month	very Day Ye	ar
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions con	tributing to death but not i	resulting in the u	inderlying cause giv	en in Part I.			acco use co		the cause of dea	
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ion of	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)		of 28c. Injur		28d	. Describe ho			,	
Division	ital or Atterins after de	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Płace of Injury - A building, etc. (Spe	t home, farm, si ecify)	reet, factory, office		28f.	Location (Sti City or Town		nber or Ru	ral Route Numbe	er,
	o the Hospital thin 24 hours a the Funeral I mpletely filled	Medical	29a. Certifier 1 X Certifying Phy: (Check only one) 2 Medical Exami	sician: To the best of my siner: On the basis of exam and manner stated.	knowledge, dea ination and/or in	th occurred at the tin nvestigation, in my o	ne, date and pinion, death	place, and occurred a	due to the ca at the time, da	use(s) and rate and place	manner as e, and due	stated. to the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of certifier	Jun		29c. Licens	e number -16746	CORN	1 6	**		n, Day, Year)	
	10 (10)		30. Name and address of person who co		tem 23a) (Type	, Print) NA	TIONAL	NAVA	L MEDI		1		
o la	Sta Registr		LEE VANCE LCDR M  31. Date filed (Month, Day, Year)  MAY 18 20	C USN  32 Registrar's Signature	gnature	BE SEL	τυσουΑ	ב עוניו	0889-5	000			

		-	For State Registrer	State of M	•	partment of H		ental Hygie Reg.	- 2000	17634
			Decedent's Name (First, Middle, Last	<u> </u>				2. Date of Death		3. Time of Death
	Physicia	_	Rose M. Penn					Month May 12,	Day Year 2006	12:51P <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give	street and numbe	r)	4b. City, Town, or	r Location of Death	110, 10,	4c. County of Dea	
	LAGITIII	CI	Holy Cross Hospi	t a 1		Silv	er Spring		Montgo	merv
	Funeral		5. Social Security Number 6. Se	7. A	Age (In yrs. last birthd	11 11 11 11 11 11 11	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Bi	rthplace (State or Foreign
	Director		140-03-4919	]M 2 <b>X</b> ∫F	93 Yrs	·	110210	Apr 19,		lew Jersey
	p ,		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	Location				10d. Inside City Limits
	anyla	_	Tod. State							1 ☐ Yes 2 ☐XNo
	he M	ecto	Maryland Montgo  10e. Street and Number	mery	Rockvi	.11e		100	. Citizen of What C	Country?
	with	ā		- "0	0.1					
	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ahow the Madical Exemples must be mollified at	by Funeral Director	1801 E. Jefferso	n St, #3		3. Was Decedent of H		cify Yes or No-	USA 14. Race - Am	rerican Indian,
	ter d	ᆵ	1 Never Married 2 Married	Armed Force 1 ☐ Yes 2 2	s?	If Yes, specify Cuba	an, Mexican, Puerto I	Rican, etc.)	Black, Wh	ite, etc.
39	urs af	by	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates		1 ☐ Yes 2X No	Specify:		Specify:	White
Ö	2 hou	Completed	15. Decedent's Ed	ucation	16a. De	ecedent's Usual Occup	pation		b. Kind of Busines	s/Industry
212	thin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4o	Tit	e. DO NOT use retired	d)	.9		
2	or th	Con	12			Homemake			Own Ho	me
밀	d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Mai	iden Sumame)	
<u>ya</u>	Men	၉	Philip Miller					a Finkelı		7. 0.41
Maryland 21215-0036	Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hysiene.  tent: If item 27 Is marked other than "natural", or Items 23s or 28s-1 show into other traumatic event, the Madical Examinar must be notified as in the matter of the configuration.		19a. Informant's Name/Relationship (7	ype, Print)	Î	ailing Address (Street				Zip Code)
ď.	l and tealth im 27	- 1	Alan Penn/Son 20a. Method of Disposition			Clemson Ct			0850 c. Location - City o	r Town State
Ö	First P		1 N Burial 2 ☐ Cremation 3 ☐		te cemetery,	crematory or other plac	ce)		•	
ţ	t. Pa tmen tant:		4 Donation 5 Other (Specify		King I					Church, VA
Baltimore,	permit. Departm Importa any Inju		21. Signature of Funeral Service Licen	See	0 0	22. Name and Addre				пр. MD 20904
		17	23a. Part1. Enter the disease, or comp	ications that caus	sed the death. Do not					Approximate
			shock, or heart failure. List only	cause on each	line.					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	Severe P as a consequence of).	neumonia				
	Examiner		1	Due to (or		Malignanc	37			
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Oue to (or	as a consequence of)	narranane	7			
	uted d ansit	Examine	Cause (Disease or injury that initiated events	c						
ó	be executed sicien and burial-transit	E	resulting in death) Last	Due to (or	as a consequence of)					
8760,	The law requires that the death certificate be executed as been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	dlcai		d						
9	artifica ing p	0	IF FEMALE:						1	
Box	ath certific attending p for use as	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 ☐ Ectopic pregnancy	у		23d. Date of d Month	elivery Day Year
<u>o</u> .	of the de by the e tached f	Physician/M	1 ☐ Yes 2X☐ No 9 ☐ Unknown	4 □ Pregnani 9 □ Unknowr	t at time of death	5 ☐ Other (specify) _				
<u>a</u>	thet the		Part II. Other significant conditions of	ontributing to deat	h but not resulting in th	ne underlying cause gru	ven in Part I.	23e. Did tobac	cco use contribute	to the cause of death?
of Vital Records,	sign sign d be	d by	Atrial Fibrilati	on				1 🗆 Yes	2 No 3 1	Probably 4 XUnknown
Ö	w requ	ete						24a. Was an	24b. Were a	autopsy findings available
Re	The lav	Completed	Congestive Heart	. rallule				autopsy	d? death?	
ā		Č	25. Was case referred to medical				26. Place of Death	-	No 1 ⊔Ye	as 2 No
<u> </u>	ysicia is cert direct	To B	examiner? 1 ☐ Yes 2√☐ No	Hospital: 1 X Inpa	atient 2 ER/Outp	atient 3 DOA Oth	nar	me 5 Residence	ce 6 □Other (Sp	pecify)
0	유 그 등		27. Manner of Death	28a. Date of I	njury 28b. Tin Day Year) Inju		ry at :	28d. Describe how	injury occurred	
<u>5</u>	uttending I death. ctor: After y the funer	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	1			]Yes 2 □No			
Division	or Attendated after death Director:	Certification:	3 Suicide 6 Could not be determined	288. Place of	Injury - At home, farm etc. (Specify)	, street, factory, office		28f. Location (Stree City or Town, S	et and Number or I State)	Rural Route Number,
	ital or urs afte ret Din lled in		V							
	To the Hospital or At within 24 hours after or To the Funerel Diract completely filled in by	edical	29a. Certifier 1 ⚠ Certifying Ph (Check only 2 ☐ Medical Exan	niner: On the basis	s of examination and/o	death occurred at the ti or investigation, in my o	me, date and place, a opinion, death occurr	and due to the caused at the time, date	se(s) and manner a and place, and di	as stated. ue to the cause(s)
	thin 2 tha tha mple	Med	29b. Signature and title of certifier	and manner	Stateu.	29c. Licens	se number	29d	. Date signed (Mg	nth, Day, Year)
)			· ( MMs7	MAN	(MM)	DR	63579		5/12/	2006
7	3		30. Name and address of person who	completed cause	of death (Item 23a) (To	voe. Print)			. ,	
			Dr. M. Jauag				r Spring.	MD 20910		
440	Sta	ate	31. Date filed (Month, Day, Year)	32. Peg	istrar's Signature	A. M.	- Prints	WUJIU		
	Regist	rar	MAY 18 2	2006	istrar's Signature	years.				

			Please	Type of Print is				_		gibie.		
			For State	State of Maryla	-			Mental Hy	giene	100	170	OF
			Registrar		Ce	rtificate of	Death		Reg. Na	JU6	1/0	133
**	Physici	an	Decedent's Name (First, Middle, Las					2. Date of De Month	Day	Year	3. Time of	
er s	/Medic		William Charles	Prensky					16, 2		8:11	P M
	Examin	er	4a. Facility Name (If not institution, give				or Location of Deat	h		inty of Death		
100	<u> </u>	<u> </u>	5207 Woodlyn Road		/- 4 5 45 4- 1- 1	Frede		0.00		rederi		
	Funeral Director		114-24-9253	7. Age (III )	vrs. last birthday)	Months Days		(Month, Da	y, Year) 1930		olace (State or ntry) York	' Foreign
	pug *	-	Usual Residence of Decedent  10a. State 10b. County	10c	City, Town or Lo	ocation					10d. Inside Cit	v Limits
	sho	2									1 ☐ Yes	
	the A	Directo	Maryland Frederi  10e. Street and Number	.ck	Frede	10f. Zip Code			10g Citizen	of What Cour	ntry?	
	with ba or		5207 Woodlyn Road	I			21702				States	
	ns 2%	Funeral	11. Marital Status	12. Was Decedent Ever in	n U.S. 13.		Hispanic Origin? (S ban, Mexican, Puer	pecify Yes or No		Race - Americ	can Indian,	
10	r Itar	Fun	1 ☐ Never Married 2XX Marned	Armed Forces? 1⊠Yes 2□Nol 9	J4-			o Rican, etc.)		Black, White,	etc.	
ĕ	raf', c	þ	3 Widowed 4 Divorced		956	1 □ Yes 2XX No	o Specify:		Spe	ecify: W	hite	
2-0	within 72 hours after death with the Maryland ene. Itan "natural", or Itams 23e or 28e-f show fre Medical Exercites mast be notified at	Completed	15. Decedent's Ed (Specify only highest gra-	ucation de completed)	16a. Dece (Give	dent's Usual Occu	upation e during most of wor	king	16b. Kind o	f Business/In	dustry	
2	ithin nan Ma	npl m	Elementary/Secondary (0-12)	College (1-4or 5+) 5+			e during most of wor ed)		T. *	1. 1 .		
2	led w lygier her ti		17. Father's Name (First, Middle, Last)	<u> </u>	Meci	nanical 1					Enginee	ring
and and	be fi	Be						ne (First, Middle,		name)		
ž	hould d Mer mark matic	٦	Louis Jacob Prens 19a. Informant's Name/Relationship (7)		10h Maili	na Address (Strot	Lillia: et and Number or Ru	n Orloff		um Ctata Tie	Codel	
<u>8</u>	d 2 s th an 7 is r		Tina B. Prensky /			•	Rd., Fre				(0000)	
ည်	1 an Heal tem 2		20a. Method of Disposition		b. Place of Dispo	sition (Name of	1	Date		on - City or To	own, State	
<u>no</u>	ages ant of it: If i		1 ∰Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Resth emorial	natory or other playen	Mary 1	9,2006	Frada	riok	Maryla:	nd
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itama 23a or 28a-1 show any nury or other traumatic event, It a Madical Exactinat must be rediffied at ADE.		21. Signature of Funeral Service Licen				ray i refuñaral					na
B	Per Character Pe		1/11/1				ctin Mtn.					
	à		23a. Part1. Enter the disease, or composhock, or heart failure. List only	olications that caused the d						120	Approximate Interval Betw	
ı	Physician		Immediate Cause (Final	Congestive							Onset and D	
	/Medical		disease or condition resulting in death)	Due to (or as a con-		arrure					115.	
	Examiner		Sequentially list conditions.	<sub>b.</sub> Cardiomyop	athy					25	Yre.	
	₽ ₩	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con-	sequence of):							
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.								
760,	ie be executed /sician and e burial-transit	cal E		Due to (or as a con:	sequence or);							
687	w - w			d								
9 X	leath certificate attending phy I for use as the	Physician/Med	IF FEMALE:	23c. If yes, outcome of pre	onancy				224	Date of delive		
Вох	atter   for u	clar	in the past 12 months?	1 Live birth 2 ☐ F	etal death 3	Ectopic pregnand Other (specify)	су		230.	Month	,	•ar
o.	the d y the sched	Ish	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		5 Care: (apreny)						
υ, σ	The law requires that the death certifical tile has been signed by the attending phyage 2 should be detached for use as the		Part II. Other significant conditions co	ontributing to death but not	resulting in the u	nderlying cause g	oven in Part I.	23e. Did t	obacco use o	ontribute to the	he cause of de	ath?
rds	quire n sig uld bi	Completed by	Diabetes					10'	res 2.⊠XNo	o 3□ Prot	ably 4 🗆 U	nknown
000	aw requir s been si 2 should l	olet	Hypertension					24a. Was		b. Were auto	psy findings a	vailable
Ĕ	The lav	E							rmed? 255No	death?	mpletion of ca	use of
ta	Physician: The la r this certificate has ral director, page 2	Bec	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only o				
<u>~</u>	hysic his ce I dire	10	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2	2 ☐ ER/Outpatier	nt 3□ DOA O	ther: 4 Nursing H	lome 5√√ Resid	dence 6	Other (Specif	y)	
ם	ng P		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	r) 28b. Time o	f 28c. Inju	ury at ork?	28d. Describe I	now injury oc	curred		
<u>s</u>	Attending Physician: r death. ector: After this certifics by the funeral director, g	catl	2 Accident investigation 3 Suicide 6 Could not be				□Yes 2□No					
Division of Vital Records, P.O.	l or Attending Ph after death. Director: After th I in by the funeral	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Spi	At home, farm, str ecify)	eet, factory, office	9	28f. Location (S City or Tox	Street and Nu vn, State)	imber or Rura	il Route Numb	1 <b>0</b> 1,
_	To the Hospital or Attenwithin 24 hours after deati To the Funeral Director: completely filled in by the	edical C	(Check only 2 Medical Exam	ysician: To the best of my niner: On the basis of exam	knowledge, deat	h occurred at the	time, date and place	, and due to the	cause(s) and	manner as s	tated.	
	To the li within 2. To the fi complet	Med	29b. Signature and title of certifier	and manner stated.			nse number			ned (Month,		
1	5 1 ½ L 8		Shorme	in Cil	1 ml	)					- wy, rodr/	
,	Alu		30. Name and address of person who of	completed cause of death	11   V		0012697	1	May 17	, 2006		
1	AVIT		Sherman Kahan, M.				307 Fra	derick	MD 217	0.1		
1	Sta	te	31 Date filed (Month Day Year)	32 Pagietrar's Si	ignatur	la. V.	JUI, FIE	TELTCK	ELU ZI/	V.L		
4	Registr		MAT 132	006	14 19							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 0045 Platt Everett Lee 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) ALLE GAN moerland SACRED HEART HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days Hours Months 1♥M 2□F 02/23/1925 Maryland 218-16-4312-A Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Allegany Cumberland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21502 12400 Crossroad Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No 1943 - If Yes, Give Year or Dates: 1946 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9 Laborer Tire and Rubber 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Platt William Robert Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carrie O. Platt 12400 Crossroad Court, Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 05/27/2006 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signatury of Foneral Service Licensee 404 Decatur Street, Cumberland, MD

Physiciar /Medica Examine

permit. Pages I Department of H Importent: If Ite any injury or ot once.

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

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**Funeral** 

Director

d Health and Mental Hygiene. Item 27 is marked other than "natural" or Items 23s or 28s-f show other traumatic event, Its Medical Examinar must be notified at

death with the Maryland

filed within 72 hours after

Pages 1 and 2 should be filed withinnent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

To the Hospitel or Attending Physicien: The lew requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the death. Do not enter the mode of dying, y one cause on each line.		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition	Lung Cancer	- Small (ell	2 months
resulting in death)	Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of).		
that initiated events resulting in death) Last	c. Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given	in Part I. 23e. Did tobacc 1 ☐ Yes	co use contribute to the cause of death? 2 No 3 Probably 4 Dunknown
		24a. Was an autopsy performed 1 Yes 2	
25. Was case referred to medical		26. Place of Death (Check only one)	
examiner?	Hospital: 1 patient 2 ER/Outpatient 3 DOA Other	4 ☐ Nursing Home 5 ☐ Residence	6 ☐Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?  M 1 Year	at 28d. Describe how in	njury occurred
3 Suicide 6 Could not determine		28f. Location (Street City or Town, S.	and Number or Rural Route Number, ate)
29a. Certifier 1 Z Certifyi 2 (Check only one)	Physician: To the best of my kno Medge, death occurred at the time aminer: On the basis of examiner ion and/or investigation, in my opi and manner stated.	, date and place, and due to the caus, nion, death occurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifier	29c. License	med 1 d	Date signed (Month, Day, Year)
//	1-31	1766	Jan 24 2006

State Registrar

within 24 hours a To the Funeral [

IVA

GOU SETONDRIVE COMBERCAND, NOD 21502

30. Name and address of pers in who completed cause of death (Item 23a) (Type, Print)

DR Vikramadity 31. Date filed (Month, Day, Year) MAY 2 5 2006

			1 - For State Registrar	State of Mary		artment of F rtificate of		lental Hygiei	2006	17637
	Physici		Decedent's Name (First, Middle, La.	Anthony	Joseph	Rzasa,	Sr.	2. Date of Death May 16, 2	2006 Year	3. Time of Death 11:09 A M
S .	/Medic Examir		4a. Facility Name (If not institution, given Laurel Regiona				or Location of Death		4c. County of Death	eorge's
100	Funeral Director		5. Social Security Number 6. S 196-07-7498	ex 7. Age (In	yrs. last birthday) 85 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye June 5,		place (Štate or Foreign ntry) nsylvania
	he Maryland 8a-f ehow	ector		George's	c. City, Town or Lo	New Car	rollton	1.0-	Citizen of What Cou	10d. Inside City Limits 1    Yes 2 No
	23a or 2	Funeral Director	10e. Street and Number 8314 Nicholson			10f. Zip Code			USA	
036	72 hours after death with the Maryland natural', or itema 23a or 28a-f ehow dissal Exarili ar musi be mutified at	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ MyVidowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ZYes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of I II Yes, specify Cub 1 ☐ Yes 2 🛣 No	Hispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify:	can Indian, etc. ite
21215-0036	within 72 hosene. than "natu	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 9th	ducation ade completed) College (1-4or 5+)	(Give	DO NOT use retire	during most of work ad)	in <i>g</i> 16b	. Kind of Business/In	•
	ould be filed withi Mental Hygiene. arked other than atic event, the M	Be	17. Father's Name (First, Middle, Last, Andrew Rzasa	)		Repairma	18. Mother's Name	e (First, Middle, Marc anne Rusn		te
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural", or Itema 23a or 28a-f ehow any injury or other traumatic event. The Modical Exaction at must be notified at once.	T	19a. Informant's Name/Relationship (	Removal from State	100 20b. Place of Dispo cemetery, crea Arlingtor	034 Worre of matory or other plan National National National Name and Address Name and Addr	and Number or Rura 11 Avenue 12 (ce) 1 (al. 16/13/ ess of Facility Ren	Glenn Dotte Number, Ch Glenn Dotte 20c 2006 A don/Hale	y or Town, State, Zij 10, Nn 2 Location - City or T rlington, Funeral Ho	0769 own, State
	Physician		23a. Pan1. Enter the disease, or conshock, or heart failure disease only immediate Cause (Final disease or condition	one cause on each line.		ter the mode of dy	apolis Roa ng, such as cardiac		MD 20706	Approximate Interval Between Onset and Death
8760,	Medical Examiner  Assician and he burial-transit	dical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	onsequence of):					
P.O. Box 6	death e atter id for u	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify)	у		23d. Date of deliv Month	ery Day Year
	w requires that the been signed by th should be detache	þ	Part II. Other significant conditions (	contributing to death but n	ot resulting in the u	ınderlying cause gı	ven in Part I.	23e. Did tobacc	co use contribute to t	he cause of death?
Il Records,	The law rete has be page 2 sh	Completed						24a. Was an autopsy performed	? prior to co	opsy findings available impletion of cause of
of Vital	Physician: Th this certificate ral director, pag	Be	25. Was case relerred to medical examiner?	Hospital:	-	Ot	hor	(Check only one)		
ion of	ding After fune	atlon: To	1 Yes No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	2 ER/Outpatier 28b. Time o Injury	of 28c. Inju	4 🗆 Nursing Ho	me 5   Hesidence 28d. Describe how in	e 6 □Other (Special Originary occurred	(y)
Division	i Sign	Certification:	3 Suicide 6 Could not be determined	building, etc. (S	Specify)			City or Town, St		
	the Hospital nin 24 hours a the Funeral I npietely filled	Medical	(Check only 2 Medical Examone)	nysician: To the best of miner: On the basis of exa and manner stated	amination and/or in	ivestigation, in my	opinion, death occurr	ed at the time, date	and place, and due t	o the cause(s)
)	To To Com	Σ	29b. Signature and title of certifier  Correct	re Poser	MP	DOC	se number ) 43829		Date signed (Month, $18/0$ )	
2	(12)		30. Name and address of person who Caroline Poplin,	M.D., Natio	n (Item 23a) (Type, onal Nava		l Center,	8901 Wisc		20889 Bethesda
	Sta	ate	31. Date filed (Month, Day, Year)		Signature	700				

		-	For State		State	of Ma	ryland /	-	artment of H		nd M		iene	006	17638
	- F	5	Registrar  1. Decedent's Name	(First, Middle, L	ast)							2. Date of Dea	th	12 12 14	3. Time of Death
	Physicia	_		Paul	Ranto	rri ah						Month May 18	Day	2006	6:45 a M
	/Medic		Peter  4a. Facility Name (II						4b. City, Town, or	Location of	f Death			unty of Death	
, in	Examin	er	Manor Care	_	70 01.001 = 10 11				Silver Spr	ina			7	Montgome	rv
es.		i ya	5. Social Security Nu		Sex	7. Age	(In yrs. last	birthday)	If Under 1 Year	If Under 2		8. Date of Birth	1		place (State or Foreign ntry)
	Funeral Director		189–14–6703		1 <b>ऒ</b> M 2□ F		83	Yrs.	Months Days	Hours	Min.	(Month, Day			sylvania
н			Usual Residence of									000001			
	yland		10a. State	10b. County			10c. City, To	own or Lo	cation						10d. Inside City Limits 1 □ Yes 2 No
	Mar 9-1-0	to	Maryland	Mont	gomery		Wheato	m							T Tes 24-1NO
	n 28	Directo	10e. Street and Num	ber					10f. Zip Code				10g. Citizer	n of What Cou	intry?
	23a c	a D	11808 Vall	.eywood Dr	ive				2	20902				USA	
	deat	Funerai	11. Marital Status		12. Was De	cedent E Forces?	ver in U.S.	13.	Was Decedent of Hi If Yes, specify Cuba	spanic Orig	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Ameri Black, White	
9	or Its	F	1 Never Marrie	ed 2 Married	1 Ves	s 2 No	0		1 ☐ Yes 2√☐ No	Specify:			Sp	ecit <b>Whit</b> e	
ğ	ours Fall,	d by	3 Widowed	4 Divorced	Year or	Dates: 1	942-45						405 161-4	-4 D	-4
2	72 h "nætt	ete		<ol> <li>Decedent's fy only highest g</li> </ol>		d)	11	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	during most	of worki	ng	160, Kind	of Business/li	laustry
2	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Itama 23a or 28e-1 ehow ent. It a Medical Everities must be motified at	Completed	Elementary/Secon	ndary (0-12)	College	(1-4or 5-	-)			,			Des		
'n	iled v tygie ther t		12 17. Father's Name (	First Middle Las				Mech	anic	18. Mothe	r's Name	(First, Middle,			ortation
and	ntal h	Be	Melee Rant		,					Ma	nrsz Dir	agich			
څ	d Me nark natic	ဥ	19a. Informant's Na		(Type Print)		1	19b. Mailii	ng Address (Street				r, City or T	own, State, Zi	ip Code)
Ma	12 sin and 7 is r			121											
o,	1 and Healt em 2 ther		20a. Method of Disp	ntovich/	Wife	-	20b. Place	of Dispo	Valleywood sition (Name of		WILES	Date	20c. Loca	tion - City or T	own, State
Baltimore, Maryland 21215-0036	in it		1 □ Burial 2 ≸	Cremation 3		m State		·	matory or other place	1	May	18, 006 <i>i</i>	11 015000	dada 17i	wedned a
븚	a grand		4 ☐ Donation  21. Signature of Full	5 Other (Spec			Metro	The same of	an Cremator  2. Name and Addres			.00 I	чехан	dria, Vi	гуппа
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23s or 28e-f ehow amount in your or other traumatic event, the Medical Execution must be notified at any quy or		21. Signature of 1 da	1161 dt 361 VICO 210		0.		Fr	ancis J. Co	ollins	Funer			<b>2</b> 000	
			23a. Part1 Enter the shock, or hear	ne disease or co	molications tha	t caused	the death. [	Do not en	O Universit	y BIVO g, such as	cardiac o	or respiratory ar	rest,	MO 2090	Approximate
			shock, or hear Immediate Cause (		ly one cause of	n each lin	е.								Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	n	a. Pneur										2 Weeks
В	Examiner	65			Due	to (or as a	consequen	CB 01):							
1.5		-e	Sequentially list con if any, leading to im	nditions, mediate	b. Due	to (or as a	consequen	ce of):							
	ited	nin.	Cause (Disease or	riying											
	akecu al-tra	Examiner	that initiated events resulting in death) I	_ast	c. Due	to (or as a	consequen	ce of):							
8760,	death certificate be executed e attending physician and ed for use as the burial-transit	dicai			d .										
687	ficate p phy is the	edic													
Box	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent	t pregnant			of pregnancy		75				23	d. Date of deli	very
	death a atte	cia	in the past 12	months?	4∏Pre	egnant at	2 □ Fetal de time of deat		⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>					Month	Day Year
P.O.	that the de ned by the a detached f	hys	9 🗆 Unknown		9□ Un	iknown									
	res that igned to be det	by P	Part II. Other signif	icant condition	s contributing to	o death bu	it not resultir	ng in the u	ınderlying cause giv	en in Part I	٠	23e. Did to	obacco use	contribute to	the cause of death?
rds	requires een sign hould be	D D	Congestive	Heart Fai	lure, Co	ronary	Artery	_Dise	ase, Hypert	ension	·	101	res 2□	No 3 ☐ Pro	obably 4x Unknown
of Vital Record	> 0 0	Completed	Sick Sinus	Stradromo	Colon C	ncor	Timer N	Viotact	acic			24a. Was		24b. Were au	topsy findings available completion of cause of
Re	a -c a	E	SICK SIIIUS	yıkıkılılı.,	_color_c	ander,	Turky 1	-cus	.c.s,			perfo	rmed?	death?	2 No
ā	icien: Th certificate rector, pag	ပိ	Atrial Fibr	rillation- red to medical	-					26. Place	of Deat	h Check only o	-		
5		O B	examiner? 1 ☐ Yes 2★		Hospital: 1	☐ Inpatie	nt 2□EP	VOutpatie	nt 3 DOA Oth	05		ome 5 Resid		☐Other (Spec	cify)
		Ë	27. Manner of Deat	h	28a. Da	ate of Injur	v 28	3b. Time o		y at		28d. Describe I	now injury	occurred	
lon	ding F th.: After a funera	tiol	1 X Natural 2 ☐ Accident	5 Pending investiga		monur, Day	/ 10ai)	Injury		Yes 2	No				
Division	r Attending ter death. irector: After	ifica	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	ad 288. Pi	ace of Inju	ury - At home c. (Specify)	e, farm, st	treet, factory, office			28f. Location (S City or Tox	Street and	Number or Ru	ral Route Number,
ā	after after Direction	Certification:	4   Homicide		, DL	Jaging, etc	с. (эрөспу)					Only or You	, otato,		
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in b		29a. Certifier	1⊠ Certifying	Physician: To	the best	of my knowle	edge, dea	th occurred at the tr	me, date ar	nd place,	and due to the	cause(s) a	nd manner as	stated.
	ne Hc n 24 i ne Fu sletely	edicai	(Check only one)	∠   Medical E	and m	e basis of	examination	i and/or ii	nvestigation, in my o		au occur	ושט מנ נווש נווווש,			
	To the within 2 To the complet	Ž	29b. Signature and	title of certifier	/	),	_1		29c. Licens		36	Ma		signed (Monti	
			1	thu	erad	la	2000	714	I) D	005	16	30	May	18, 2	006
	10+1		30. Name and add	ress of person w	ho completed c	ause of d	eath (Item 2	За) (Туре	, Print)				7.		
			Anuradha	Arun, M.D	. 1030	l Geor	gia Ave	enue,	#209, Silve	er Spri	ing, M	1D 20902			
28		ate	31. Date filed (Mon	nth, Day, Year)		Registra	ar's Signatur	θ /	arkes						
# A	Regist	třar	TV8	HI TA	2006	E 12.26.	1 St.	A. P.	74861						

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** 14, Sarah Epps Robinson May 2006 3:30 p M /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Household of Angels Asst. Living Gambrills Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 21,1909 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sex **Funeral** Months Days Hours Min 1 ☐ M 2 🖾 F Yrs. 416-10-8242 96 Alabama Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28a-1 show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No MD Anne Arundel Gambrills Director 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code or items 23s or 21054 2163 Davidsonville Road USA within 72 hours after death Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: þ 3 XWidowed 4 □ Divorced 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done di life. DO NOT use retired) during most of working Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Office Manager Social Security other t permit. Pages 1 and 2 should be file Department of Health and Mental Hy, important: If item Z7 is marked other any injury or other trailmests. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Thomas Wiley Epps Amanda Weir 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David C. Petrillo/Peraonal Rep. 23 West Street, Annapolis, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) May 22, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State Forest Hill Cemetery Birmingham, AL 4 □ Donation 5 □ Other (Specify) 21. Signature of Fune al Service Licenses 22. Name and Address of Facility Rarranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** pros /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physicien and hed for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Year detached for Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown this certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ funeral director, page 2 should be 2XINo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗆 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury Vatural 2 ☐ Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after deat To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) the th 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 000295 30. Name and address of person who completed causé of death (Item 23a) (Type, Print) Two steE Crofton, MD 21114 2225 De 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar

06-03629

#### Please Type or Print in Black Indelible Ink

nthony Walter		1- For State	tate of Maryla		artment of		and Menta	al Hy		2	006	1764
Physicia		Registrar  1. Decedent's Name (First, Midd	dle,Last)					2	. Date of Deat			Time of Death
Medical Exami		Anthony Walte	r Smith, S	Sr.					Month May 28, 2	Day Yea	ar	1713 hrs
		4a Facility Name (if not instituti	on, give street and nu	mber)	4		or Location of	Death		4c. County		
		10607 Hinkle Road				Cumberla		0.411	0 B-1(B)	Allegany		(0)
Funeral Director	- 1	5. Social Security Number		7. Age (In yrs. la	ast birthday)	If Under 1 Y Months D	ear If Under ays Hours	Mtn.		th (MM/DD/YYYY	Foreign	
Director		214-80-6495	1 X M 2 F	44	Yrs.				Aug 5,	, 1961	Count	<sup>(y)</sup> MD
any	ŀ	Usual Residence of Decedent  10a. State 10b County		10c. City,	Town or Location	on					10	id Inside City Limits
		MD A11	egany		umber1a	nd					1	YYes 2 No
Maryland 28a-f show d at once.	횽	10e. Street and Number				10f. Zip Code	e		11	0g Citizen of Wh	nat Country	?
he Ma or 2	Director	947 Maryland	Δυρμο Δτ	vt 3		215	Ω2			USA		
with t		11. Marital Status	12. Was Dec	edent Ever in U.		Decedent of	Hispanic Origi			- 14. Race		Indian, Black.
death rriten nust l	Funeral	1 Never Married 2 N	Married Armed Fo	orces?	lt Ye	s, specify Cul	ban, Mexican, I	Puerto R	ican, etc.)	White		
after al", o	by		vorced If Yes, Give Yea or Dates:	r		Yes 2X					Whit	
hours natur Exam	9	15. Decedent's Education (Sp			16a Decedent during mo		ipation (Give ki life. DO NOT u			16b Kind of Bu	siness/Indu	ıstry
36 in 72 han "	ompleted	Elementary/Secondary (0-12)	College (1	-4 Or 5+)	D C							
-00; d with greene ther t	팃	12 17. Father's Name (First, Middle	e, Last)		Roofe	r	18 Mother's	Name (F	First, Middle, M	Const Maiden Surname	<u>ructı</u>	on
21215-0036 Juld be filed within 7: Mental Hygiene, marked other than c event, the Medical	Be C	Franklin Cre	amer, II				Juani	ita (	(Smith)	German		
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		19a Informant's Name/Relation	ship (Type, Print)	<u> </u>	19b. Mailing	Address (St	treet and Numb	per or Ru	ral Route Nun	nber, City or Tow	n, State, Zi	p Code)
MD nd 2 sho aith and m 27 is aumati		Juanita Germ	anmother							, MD 2		
ore, slam of Hea If iter		20a Method of Disposition  1 Burial 2 X Crematic	n 3 Removal fro		Place of Disposit crematory or other		cemetery,		Date	20c. Location -	City or Tov	wn, State
imo Page nent c		4 Donation 5 Other S	Specify		rpelli Fur	neral Ho	me, PA	06/01	/2006	Cresapt	own,	MD
Baltimore, permit Pages I an Department of Hea Important: If iter injury or other tr		21. Sonature of Funeral Service	e Licensee	anM-	22. Na Sca	ame and Addr arpelli	ess of Facility Funeral	Home,	P.A.			
	_	23a Part I. Enter the disease, of	or complications that d	DIVIDE death	1 10	3 Virgin	nia Avenu	ie: Cu	mberland	1, MD 215	602 art 1	Approximate Interval
Physician /Medical		failure. List only one caus	e-oh each line.					i dido oi i	oophatory and	oot, onoon, or not	,	Between Onset and Death
Examiner	-	Immediate Cause (Final diseas or condition resulting in death)		consequence o	nadone int	OXICALIO	)11					
		Sequentially list conditions,	b									
	iner	if any, leading to immediate cause. Enter Underlying Cause		consequence o	f):							
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executed an and al - transit			d	1. //00	07.00	2.07	056 6 /06	104 1				
ec se initial	edical	X UNPENDED	AMENDED	item#23a	,27,28a-f	,perME,g	3856,6/2C	)/06 1	T			
Box 68760 he death certificate I the attending phys	ian/Me	IF FEMALE: 23b Was decedent pregnant in	tho	outcome of preg			3 Ectopic			23d. Date of		Vaar
certif	ciar	* past 12 months?	i Live p	ant at time of de	ath _	al death er (Specify)	3 Ectopic	pregnand	Зу	Month	Day	Year
Box 6876( e death certificate the attending phy ed for use as the b	Physici	1 Yes 2 No 9 Ur	nknown 9 Unkno	own	0	01 (=,===:,)						
, P.O. E ires that the d signed by the	by PI	Part II. Other significant cond	itions contributing to	death but not r	esulting in the ur	nderlying caus	se given in Par	t I.		bacco use contri	-	
S, P uires t n sign	g pa											y 4 Unknown
ord w req	Completed	-							24a Was autop	sy p	rior to com	sy findings available pletion of cause of
Rec The Iz icate h	E O								1 Yes		leath? ✔ Yes	2 No
Vital Records ysician: The law requi	Be (	25. Was case referred to medic examiner?	Hospital		1		ace of Death (					
Physic r this	2	1 ✓ Yes 2 No		npatient 2	ER/Outpatient 28b. Time of In		Other <sub>4</sub>			Residence 6 how injury occurr		ene
n of ding Ph.	on:	27. Manner of Death  1 Natural 5 Per		Day, Year) 2/28/2006			Yes 2 X			low injury occurr	eu	
ision Attencer ar death rector: by the	cati	2 Accident Inv	estigation 28e Plac		Fnd 4:00 ome, farm, stree	P		`	ink 8f Location (S	Street and Number	er or Rural	Route Number, City
Division of Vital Records, pital or Attending Physician: The law require ours after death.  eral Director: After this certificate has been signed in by the funeral director, page 2 should b	Certification:	det	uld not be ermined (Specify)	other		i, rabibly, ome	so bananig, etc		or Town, S Sumberlar	tate) 10607	Hinkle	Road
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		20a Cortifion	Physician: To the bes			ed at the time	e, date and place					
To the Howithin 24 For the Function To the Fun	Medical		aminer: On the basis of	of examination a								ause(s)
¥ ½ ¥ 8	Me	29b. Signature and title of certif				29c Lice	ense number			29d Date sign	ed (Month,	Day, Year)
Λ.		4	Mul			0.	C.M.E.			May 29, 20	06	
KIL1		30. Name and address of person										
Da.		David Fowler M.D.	Chief Medical E		111 Penn St		nore, MD 2	1201				
S: Regis	tate	31. Date filed (Month , Day Year	006 A 32. Re	egistrar's Signati	ire spark	,						

Registrar

		State of Maryland / Department of Healtl  State of Maryland / Department of Healtl  Certificate of Dea	th	Reg. No	2006	1641
Dharist	2	1. Decedent's Name (First, Middle, Last)	2. Date of Month	Death Da		ime of Death
Physici /Medic	al	Byron Hugh Souder, Sr.  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Locati	May	16,		25 P
Examin	er	National Lutheran Home Rockville			Montgomery	
Euporal		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Un	ider 24 Hrs. 8. Date of	Birth	9 Birtholace (9	
Funeral Director		577-05-1220   180 M 2 F   91   Yrs.   Months   Days   Hou	rs Min. (Month,	Day, Year)		
*		Usual Residence of Decedent         10c. City, Town or Location           10a, State         10b. County         10c. City, Town or Location			10d. ins	ide City Limi
sho	ŭ					Yes 2 N
Itams 23a or 28a-f show	Director	Maryland Montgomery Rockville  10e. Street and Number 10f. Zip Code		10g. Ci	tizen of What Country?	
a or		9533 Veirs Drive, #2 20850	0		USA	
ns 2:	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic If Yes, specify Cuban, Mox		No-	14. Race - American Indi	ian,
tal Hygiene. d other than "natural", or Itan svant, Ita Medical Exercities	Fun	1 Never Married 2 Married 1 1√2 Yes 2 No			Black, White, etc.	
tural', o	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: WWII	епу:		Specifwhite	
natur	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during r	most of working	16b. K	(ind of Business/Industry	
I Health and Mental Hygiene. Itam 27 is markad other than "natur othar traumatic svant, the Medical	nple	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	•			
t, the	S	12 Montgomery Cou			Law Enforce	ment
d oth	Be		lother's Name (First, Mid			
arka	ည		rancelia Cat			
is m		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Nu		-		
m 27 har t		Jane E. Souder/ Wife 9533 Veirs Driv	ve, #2, Rock		ocation - City or Town, St	310
± 5		₩ Burial 2 Cremation 3 Removal from State	May 20,	200, L	ocation - City or Town, St	ale
tant:		'4 Donation 5 Other (Specify) St. Luke Lutheran Church	2006	De	erwood, Mary	land
Important: any injury once.		21. Signature of Funeral Service Licensee Francis J. Col	acility llins Funera	al Hor	me Inc	
1 = 6 OI		Willia J Dryk 500 University				
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.	h as cardiac or respirator	y rrest,	Interv	ximate al Between t and Death
ician		Immediate Cause (Final disease or condition a	Cement	19	19	lee
dical miner		resulting in death)  Due to (or as a consequency of):			(	
	L	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
sit	ine	if any, leading to immediate cause. Emer Underlying Cause (Disease or injury that initiated events c.				
nysician and he burial-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
ician buria	cai E					
pnys the	-	d.				
ding se a	by Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
attending phy I for use as the	ciar	23b. Was decedent pregnant in the past 12 months?  1   Live birth   2   Fetal death   3   Ectopic pregnancy   1   Live birth   2   Fetal death   5   Other (specify)			Month Day	Year
eu Jec	ysi	1 Yes 2 No 9 Unknown				
gned by be detact	H.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.	Part I. 23e. D	id tobacco	use contribute to the caus	e of death?
l sign	d b	Didbeles Mellotus	1	☐ Yes 2	☐NO 3 ☐ Probably	4 Unknow
been si should I	Completed		24a. W	ns an	24b. Were autopsy find	dings availab
2 2	E D	apena	at pe	utopsy erformed?	prior to completio death?	n of cause o
or, pa		05. Was associated to modical		s 2 ☑ No	1 Yes 2 N	0
After this certificate has b funeral director, page 2 s	o Be	examiner?	Place of Death (Check on	*	0.500	
After this funeral di	}	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	ursing Home 5 ☐ R 28d. Descri			
c <b>tor</b> : Afte y the fune	tior	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2	2 🗆 No			
y the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office			nd Number or Rural Route	Number,
0.0	erti	4 ☐ Homicide building, etc. (Specify)	City or	Town, State	9)	
2 =		29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.				iuse(s)
Funaral Ditely filled in	<u>=</u>	29b. Signature and title of certifier 29c. License numb	ber	29d. Da	ate signed (Month, Day, Yo	ear)
mpletely filled in	Medical			00		
completely filled in by the	Medic	200 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	77/	- 1/ // I	a . 10 a	1
To the Funaral Di completely filled in	Medic	Chalel W. Kerresh MD 021	726	1/1	ay 17,20	506
To the Funaral Diractor:	Medic	39. Name and address of person who completed cause of death (Item 23a) (Type, Print) Way les Kayesh MD 26033 Ridge Ro	726 1., Damo	1/1	ay 17,20	006

State of Maryland / Department of Health and Mental Hygiene UU 0

1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Grace Staling **Physician** Leah Miller 12 04:54 A M 2006 mar /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hagerstown Washington County Washington County Hospital 8. Date of Birth (Month, Day Till V 2 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6 SAY ,1910 **Funeral** 1 □ M 2 X F Months Martinsburg, WV Director 220-36-6898 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code - 23a 21740 United States 333 Mill Street permit. Pages 1 and 2 should be flied within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other then "neturel; or itema 23s any injury or other traumatic event, the Madical Examiner must once. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 1 Never Married X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: Yes. Give If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Physiologist University Of Maryland 5 years 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Unknown Unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Retationship (Type, Print) 20009 Rosebank Way #248 Hagerstown, MD 21742 John David Staling (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Onation 5 ☐ Other (Specify) Howard Medical School 5/12/06 Washington.DC 21. Signature of Funeral Service, Linns 22. Name and Address of Facility Funeral Home 3821 14th Street NW Washington, DC 20011 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Renal Immediate Cause (Final Failure Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sepsi Sequentially list conditions, if any, reading to mimourate cause. Enter Underlying Cause (Disease or injury Die to for as a nonsequence off Examiner ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown I signed by the Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown as been sign Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 2 No 1 Yes To the Hospital or Attending Physician: After this certification, 25. Was case referred to medicat Be 26. Place of Death (Check only one) examiner' Hospitaf: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Maturat 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D completely filled in t Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0060396 1126 opal 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) MUR-SHEI) FARID 32. Pegistrar's Signature 31. Date fifed (Month, Day, Year) State 18 2006 Registrar

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	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location of		10, 10,		. County of De		_
			Springbrook Nurs	ing Home				Sil		Sprin				ntgomery	
	Funeral		5. Social Security Number 6. Se 115-10-8857	x 7. Ag M 2□F		ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da 01/25/	th y, Year)	9. B	rthplace (State or Foreign Country)	
2	Director	Ž.	Usual Residence of Decedent		90	. 115.					01/25/	1916	)	NY	_
	land ow		10a. State 10b. County		10c. City	, Town or Lo	ocation							10d. Inside City Limits	_
	Man,	ţċ	MD MONTO	GOMERY				SI	LVER	SPRI	NG			1 Yes 2 □ No	
	th the	Funeral Director	10e. Street and Number				10f. Zip	Code				10g. Cit	tizen of What C	Country?	
	23a	a	14514 Homecrest I						2090					S.A.	
	er dez	nue	11. Marital Status	12. Was Decedent Armed Forces?		S. 13.	Was Deced If Yes, spec	lent of His only Cuban	spanic Ori n, Mexicar	igin? (Spe n, Puerto F	cify Yes or No Rican, etc.)	-	14. Race - Am Black, Wh		
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 X Yes 2 □ ! If Yes, Give Year or Dates:	∾o WWII		1□Yes 2	2 <b>X</b> ) No	Specify:				Specify:	White	
9	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23a or 28a-1 ehow Le Medical Exercitien must be notified at	ed	15. Decedent's Edu	ucation			dent's Usua					16b. K	and of Busines	s/Industry	_
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2	ed wil	Completed	12				Ma	ınage					Liquor	Store	
ınd	be filed stal Hygi ed other event, I	Be	17. Father's Name (First, Middle, Last)	Shapiro					18. Mothe	er's Name	(First, Middle,		eJover		
Maryland 21215-0036	should nd Mer marke umatic	To	19a. Informant's Name/Relationship (T)			19h Maili	na Address	(Street a	nd Numbe	er or Rura			or Town, State,	Zio Code)	
<u>⊠</u>	od 2 s lth an 27 fs : trau		Carol Shapiro Bar		nter		-						Maryla		
ē,	f Healthern		20a. Method of Disposition		20b. PI	lace of Dispo	sition (Nan	ne of	1		ate		ocation - City o		
Ë	Pages nent of int: If it		1 Burial 2 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			ean Me	-			5/18/	2006		Olney	, Maryland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23s or 28s-1 ehow amy injury or other traumatic event, the Medical Examinar must be notified at ance.		21. Signature of Funeral Service Licens	600		1 2	Name an	d Address	s of Facilit	tv		tion			
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			23a. Part1. Enter the disease, or comp shock, or heert failure. List only o	lications that caused ine cause on each li	d the death ne.	. Do not en	ter the mod	e of dying	, such as	cardiac oi	respiratory a	rrest,		Approximate Interval Between Onset and Death	
10	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a CARDIO			REST								_
	Examiner			Due to (or as			тригот	OM							
	, * * * · ·	ē	dequeritally list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as			IFF OOL	OIN							-
	cuted	Examiner	that initiated events	С.											
,097	te be executed ysicien and te burial-transit		resulting in death) Last	Due to (or as	a consequ	ience of):									
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x 68	death certifica e ettending ph id for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnal	ncv							22d Data of d		
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o.	thet the de ed by the detached	hysi	1 Yes 2 No 9 Unknown	9□ Unknown											
э, Р	requires thet the	by P	Part II. Other significant conditions co	intributing to death b	ut not resu	ılting in the u	inderlying c	ause give	n in Part I	l.	23e. Did t	obacco	use contribute	to the cause of death?	
ord	w require been si	ted									10'	Yes 2	□No 3□F	Probably 4 XUnknown	
Records,	aw is b	Completed									24a. Was	osv	prior to	autopsy findings available completion of cause of	
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Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	•		(Check only o				
o	Phys rthis ral di	. To	1 ☐ Yes Ž No  27. Manner of Death	28a. Date of Inju	iry	ER/Outpatier 28b. Time o		8c. Injury	4AINU		ne 5 ☐ Resid 8d. Describe I		6 □Other (Sp ry occurred	ecify)	
lon	Attending I r death. ector: After by the funer	tior	Natural 5 Pending 2 Accident investigation	(Month, Da	y Year)	Injury	м	Work 1 □ Y	? ′es 2 🔲	No					
Division	er des recto by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj	ury - At ho	me, farm, st	reet, factory	, office		2	8f. Location (S City or Tox			Rural Route Number,	
Ö	itato irs aft ral Di led in														
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 X Certifying Phy (Check ovy 2 Medical Exam	rsician: To the best iner: On the basis of	f examinat	wledge, deat ion and/or in	h occurred ivestigation,	at the time , in my op	e, date an inion, dea	nd place, a oth occurre	nd due to the ed at the time,	cause(s date an	) and manner a d place, and du	as stated. ue to the cause(s)	
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner st	ateu.		290	: License	mumber /	<i>,</i>	,	29d. Da	ite sigded (Mor	nti <b>y</b> , Day, Year)	
	or Too			$\sqrt{}$				(	4	//	17	(	(1/1)	1	
7	4		30. Name and an ress of person who co	ompleted cause of o	death (Item	23а) (Туре,	Print)		, 0	L	1 /	10	1111	y 6	-
	-		NASREEN KANGO, M				, SUI	TE 20	)5, T	'AKOM	A PARK,	MAI	YLAND	20912	
	Sta Regist	ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	ture	mark!	,							
40	negist	ar	men 202	.UUU	65.00 \$	U" S	100 3								

			For State Registrar	State of M	arylan	-		nt of He te of D		Mental	Hygien Reg. N	2000	1764	13
	Physicia	an	1. Decedent's Name (First, Middle, Joseph Cecil							2. Date Mont		2006 2006	3. Time of Death	
	/Medic	al	4a. Facility Name (If not institution,				4b. Cit	y, Town, or Lo	ocation of Dea	May		lc. County of De		<u></u>
	Examin Funeral Director	er	Suburban Hospi	al		last birthday) Yrs.	Bet	hesda er i Year	If Under 24 Hrs Hours Min	8. Date	М	lontgome		gn
	p ,		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	cation						10d. Inside City Limit	-
	Aaryla f show	ō	MD Montgo	nerv		Silver		no					1≹ Yes 2 N	
	r 28a-	rect	10e. Street and Number				<u> </u>	ip Code			10g. C	Citizen of What C	Country?	_
	23a o	aiD	2201 Colston D	rive Apt.	211			20910				ted Sta		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other trsumatic event, the Medical Examinar must be notified at once.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces  1 TYes 2 If Yes, Give Year or Dates:	Ever in U No 194 1945	· J –		3.7	eanic Origin? ( Mexican, Pue Specify:	Specify Yes rto Rican, etc	or No- c.)	14. Race - Am Black, Wh Specify: W		
5 0	72 ho	eted	15. Decedent's (Specify only highest	Education grade completed)		(Give	kind of v	sual Occupation	on ring most of wo	orking	16b.	Kind of Busines	s/Industry	
121	within one. then "	ld m	Elementary/Secondary (0-12)	College (1-4or	5+)	Veter	DO NOT	use retired)			An	imal Me	dical	
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Man	2 sho and i is mu		19a. Informant's Name/Relationshi				-					or Town, State,		
e,	1 and Health iem 27		Gladys D. Shaft	er -spouse	20b. F	lace of Dispo	sition /A	ame of	0r. #21	I Silv		ring, M		
TO TO	gent of ment o		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp.			emetery, crer Arara			May	19 20	06Farı	mingdale	, New York	
Baltimore, Maryland 21215-0036	permit. Depertm Imports sny Inju		21. Signature of Funeral Service L					and Address	J	_		r's Son		
			23a. Part1. Enter the disease, or o shock, or heart failure. List o	omplications that cause nly one cause on each !	d the deat ine.								Approximate Interval Between	
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.O. Box	at the death certifi by the ettending I tached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	I death 3	⊒Ectopic ] Other (	pregnancy specify)				23d. Date of do Month	əlivery Day Year	
Records, P.	law requires that the as been signed by th 2 should be detache	Ď	Part II. Other significant condition Abdominal Herni	•		ulting in the u	,	•	in Part I.	23e.	Did tobacco		to the cause of death?  Probably 4 □Unknow	n
eco	e law re has bee ge 2 sho	Completed	Acute Renal Fai	lure							Was an autopsy	24b. Were a	utopsy findings available completion of cause of	е
<u>س</u>	The page	Con	Cerebrovascular	Accident						101	performed? ∕es 2⊡ N		s 2 No	
Vital	sicisn: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	Hospital:	00	ER/Outpatier		Other	6. Place of De			a = 0.1. (0.		
10	or Attending Physicisn: fter deeth. Director: After this certifica in by the funeral director, p	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of Inj (Month, Da		28b. Time of		28c. Injury a Work?	4   Nursing			6 ☐ Other (Sp jury occurred	өсігу)	
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Division of	tal or Attencis after deeth al Director: ed in by the l	Certification:	3 Suicide 6 Could no 4 Homicide determin		jury - At he tc. (Specif	ome, farm, str y)	reet, facto	ory, office		28f. Local City of	tion (Street a or Town, Sta	and Number or F ite)	Rural Route Number,	
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in	edicai	(Check only 2 Medical E	Physicien: To the best xaminer: On the basis of and manner s	of examina		vestigati	on, in my opin	ion, death occ		time, date a	nd place, and du	e to the cause(s)	
	To 1	Σ	29b. Signature and title of certifier	Q-e			2	9c. License n			29d. D	ate signed (Mor	ith, Day, Year)	
,	3		Rama		door ""	0 030) (7	Deine	ソバ	609		7.	, ,		
			30. Name and address of person w Raman Tull MD 1	•			•	aither	shuro	MD 20	878			
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	Registr	ar	MAY 18	/UUb Lande	n 163	TO AND DESCRIPTION OF THE PARTY	1							

JOSEPH C. Shrifter, 5/16/06, 11:08m.

	-	For State Registrar	State of Ma	ylariu /		cate of l				Reg. No.	000	5	764
Physician		1. Decedent's Name (First, Middle,						:	2. Date of De Month	ath Day		ır	Time of Death
/Medica	1	4a. Facility Name (If not institution, g	Little Sieg	jman	4h	City, Town, or	Location	l Death	MAY	16	County of De		130 A
Examine		Sinai Hospital o	f Paltimon	ρ.		altimo		Dodu		10.	county of Di	Juli 1	
Funeral			. Sex 7. Age	(In yrs. last b	oirthday) If L	Inder 1 Year	If Under Hours	24 Hrs. Min.	B. Date of Birt	h V Voar)	9. 6	Birthplace (	State or Forei
irector		213–18–8566	1 □ M 2XX F	83	Yrs.	nths Days	nours	MIII.	B. Date of Bird (Month, Da May 7,	192		aryla	
	-	Usual Residence of Decedent  10a. State 10b. County		10c City To	wn or Location							10d In	side City Limi
in in	5		roll				estmi	nstei	2				Yes 2 N
professional be notified at	Funeral Director	10e. Street and Number			10	f. Zip Code				10g. Citi	izen of What	Country?	
2	5	326 Margaret Av	enue				211	57			US	A	
Eller	e a	11. Marital Status	12. Was Decedent Ev	ver in U.S.	13. Was I	Decedent of Hi specify Cuba	ispanic Ori	gin? (Spec	ify Yes or No	.	14. Race - A		dian,
all la	2	1 Never Married 2 Married	Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	0	-	specny Cuba es 2⊠No	Specify:	i, Pueno n	ican, etc.)		Black, W		
531	20	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:			es 2 <u>00</u> 110	эрвину.				Specify:	white	= 
dical Exp	Сощріете	15. Decedent's (Specify only highest		16	a. Decedent's (Give kind	Usual Occupa of work done of OT use retired	ation du <i>ring</i> mos	t of working	9	16b. Ki	ind of Busine	ss/Industry	
	Ē	Elementary/Secondary (0-12)	College (1-4or 5+	-)		cretary				La	w Offi	.ce	
		17. Father's Name (First, Middle, La	ist)				18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)		
2	ן מ	Sterling Litt					L	ettie	Neude	cker			
	2	19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailing Ad	dress (Street a	and Numbe	r or Rural	Route Numbe	er, City o	r Town, State	a, Zip Code	)
other trau		Cynthia Schlude	, daughter		844 Gi	st Road	d, We	stmin	ster,	MD 2	1157		
othe ethe	1	20a. Method of Disposition		20b. Place	of Disposition	(Name of	e)	Da	ite	20c. Lo	cation - City	or Town, S	tate
ة ב		1X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			ohn's			5/20/	2006	Wes	tminst	er, M	$\mathbb{D}$
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ğ ğ	1	Justin R. J	Justona		91	Willis	Stre	et, w	<i>l</i> estmir	ıster	, MD 2	21157	
Physician /Medical Examiner		23a. Part). Enter the disease, or conditions which, or heart lailure. List or immediaty Cause (Final disease or condition resulting in death)  Sequentially list conditions	aOLOY\ Due to {or as a	Cancer consequence	e ol):	40.00	nbus	s					val Between et and Death
2	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence	e of):	rdoli						2	week
9	calEx	resulting in death) Last	d. Due to (or as a	consequence	e of: Label	Fall	ive_					2	weeks
as th		IF FELLAL F											
detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal dea		pic pregnancy er (specify)					23d. Date of o Month	delivery Day	Year
deta		Part II. Other significant condition	s contributing to death but	t not resulting	in the underly	ring cause give	en in Part I		23e. Did t	obacco u	ise contribute	to the cau	se of death?
, B	d by	Sepsis							10	res 2	□ No 3 □	Probably	4 Únkno
should	Completed								24a. Was	an	24b. Were	autopsy fir	ndings availa
page 2	Ĕ									rmed?.	death	to completi ? 'es 2□ t	ndings availa on of cause o
g.	ge C	25. Was case referred to medical					26 Place	of Death	1 ☐ Yes Check only o	-	101	85 201	10
2	0 0	examiner?	Hospital: topatien	it 2□ER/0	Outpatient 3	DOA Othe	0.0		e 5□Resi		6 □Other (S	pecify)	
eral di		27. Manner of Death	28a. Date of Injury (Month, Day		. Time of Injury	28c. Injun Worl			3d. Describe I			,,	
by the fur	Certification:	1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	tion	ry - At home,	N	1 1	Yes 2□		Bf. Location (			Rural Rou	te Number,
		29a. Certifying	Physician: To the best of kaminer: On the basis of	f my knowled	ge, death occ	urred at the tim	ne, date an	d place, ar	nd due to the	cause(s)	and manner	as stated.	(a)esus
the r	Medical	one)	and manner stat	ed.		,							
3	<	29b. Signature and title of certifier	m	1//	1	29c. License				Zyo. Dai	te signed (Mo	лип, <b>∪ау</b> ,	ear)
		round	1110	wil	n	000	389	t 2		Ma	416	,20	06
λ		30. Name and address of person w		. 1 .	(Type, Print	nnore				4	J		
7		Found Abbas . n	10 Sinai Ha	Spi tall	MY TYLL	INVIONE.	DUD.	1 11116	+ 1 JUlla	0 M	e 1001 h	WIN.	VWVI OIL

DHMH 17 Rev 1/2001

	2	_	For State Registrar	State of	Marylan		artment rtificate			ind M		Reg. No	$-2 \Omega$	06	-	646
/M	sicia edica mine	al .	Decedent's Name (First, Middle, I  Toku M.  4a. Facility Name (If not institution, g.)	ary Sug	iyama		1		Location of	f Death	2. Date of De Month May	Da 1		2006 of Death	3. Time o	:15p <sup>M</sup>
Fune Direc	ral		Shady Grove Adve: 5. Social Security Number 6 213-30-8062		pital Age (In yrs. 84		If Under 1	CKVi 1 Year Days	11e If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Sept.	th		gomer 9. Birthpla Countr Calif	ce (State	or Foreign
D		tor	Usual Residence of Decedent  10a. State 10b. County  MD Baltin	more	10c. Cit	ty, Town or Lo	ocation								d. Inside C	
h with the		Funeral Director	10e. Street and Number 959 Ellendae Dr	•			10f. Zip (	Code 1286				10g. Ci		What Counti	y?	
ie, wan yian a factory and 2 should be filed within 72 hours after death with the Maryland Freath and Mental Hygiene. Item 27 is marked other then "netural", or Items 23a or 28a-f show what tening the market of the factory of the market of the factory.		2	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Deced Armed Force 1	es? √TvNo	1	Was Decede If Yes, speci 1 Yes 2		spanic Orig n, Mexican Specify:	gin? (Spe , Puert <i>o</i>	ecify Yes or No Rican, etc.)	)-		e - America ck, White, et	c.	
J within 72 ho jiene. r then "netur		Completed	15. Decedent's (Specify only highest to Elementary/Secondary (0-12) 12	Education grade completed) College (1-4	or 5+)	(Give life.	dent's Usual kind of work DO NOT use -Emplo	k done d e retired)	urina most	of worki	ing			Teach		
hould be filed d Mental Hyg marked othe		To Be C	17. Father's Name (First, Middle, La Sakae Koda  19a. Informant's Name/Relationship			19h Mailir	ng Address	(Street a	Kuni	ko I	(First, Middle)  Kosaka  al Route Numbe				Code	
of Health and It is it item 27 is it			George Sugiyama/ 20a. Method of Disposition 1 Burial 2000 Cremation 3	Son	20b. F		ort W	illi	ams P	kwy	Alexan	dria	, VA		04	
permit. Pages 1 and Department of Health Importent: If Item 27	once.		4 Donation 5 Other (Society Structure of Funeral Service )	cify)			2. Name and	Addres			phy FH			.1y, V	Α	
Physici /Medic			23a. Part1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. CON	ch line.	th. Do not ent	er the mode	of dying	, such as o	cardiac d	or respiratory a				Approxima nterval Be Onset and	tween Death
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and proportion in the funeral director after the certificate has been signed by the attending physician and the funeral director after the funeral director and 2 should be detained for the as a the hurst larger.		ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	r as a conseq	quence of):	CAL	10/0	~Y0	P4:	MY			2	272	2SIA
wrequires that the death certificates that the attending pt		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		th 2 ☐ Feta nt at time of d	aldeath 3[	Ectopic pre						23d. Dat Mo	te of deliver		Year
equires that en signed b	8	፳	Part II. Other significant condition	•		sulting in the u		iuse give	n in Part I.					ribute to the 3 ☐ Probai		
sician: The law recording to the second to t	ı l	e Completed	25. Was case referred to medical								1 ☐ Yes	ormed?		Were autops prior to com death? I Yes 2	y findings pletion of	s available cause of
Physicia r this certi		ToB	examiner?  1 Yes 2 No  27. Manner of Death	Hospital: 1 🗹 In		ER/Outpatier			r. 4 🗆 Nui	rsing Ho	n <i>(Check only o</i> me 5 ☐ Resi 28d. Describe	dence				
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely in the thouse director and		Certification:	1 Matural 5 Pending 2 Accident investiga 3 Suicide 6 Could no 4 Homicide	be 28e. Place o		Injury	М		? ′es 2 □ N	No	28f. Location ( City or To	Street a	nd Numb		Route Nur	n <i>ber</i> ,
Hospital of 24 hours af Property Description	area area area area area area area area	Medical Ce	29a. Certifier 1 Certifying (Check only one)	Physician: To the base	is of examina	owledge, deat ation and/or in	h occurred a vestigation,	at the tim	e, date and inion, deat	d place, th occurr	and due to the ed at the time,	cause(s date an	and ma d place,	anner as sta	ted. he cause(	(s)
To the To the		Me	29b. Signature and title of certifier  OULC  30. Name and address of person w	T MO	of doath (Ita	m 23a) (Type	D Print)	00			4	MA	7 1			06 dC
4	Stat	_	31. Date filed (Month, Day, Year)  MAY 1 9 200	2 am	MAD	Y CIR	SUO	AC	VEN	277.5	7 648	276	115	AL	-	·

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	laryland / Depa	artment of F		/lental Hy	giene Reg. No. 20	06	17	64
			1. Decedent's Name (First, Middle,	Last)				2. Date of De	eath Day	Year	3. Time o	f Death
ı	Physici /Medio		Marian S.	Sa	fford				15, 200		4:25	a M
	Examir		4a. Facility Name (If not institution,	give street and number	r)	4b. City, Town, o	r Location of Death		4c. County	of Death		
			Sharon Nursing	Home		Sand	ly Spring			Mont	gomery	<i>7</i>
	Funeral		,	6. Sex 7. A 1 ☐ M 2 🔀 F	ige (In yrs. last birthday)	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ay, Year)	9. Birth	lace (State	or Foreign
	Director		127-09-5869		88 Yrs.			May 4,	1918	New	York	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside C	ity Limits
	Manyl 1 sho	ō	Maine Penobs	ant	Mi 17 in a al-	-+						2 <u>₹</u> No
	the 28s	rec	10e. Street and Number	COL	Millinock	10f. Zip Code			10g. Citizen of V	What Cou	ntrv?	
	With Se or	□	P.O. Box 313			04462	)		USA		,	
	death ms 2	Funeral Director	11. Marital Status	12. Was Deceden	t Ever in U.S. 13.		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	o- 14. Rac		can Indian,	
ယ	after or its		1 Never Married 2 Marrie	Armed Forces	No	_		Hican, etc.)		k, White,		
Ö	ral', c	j S	3√ Widowed 4 Divorced	If Yes, Give Year or Dates	:	1 ☐ Yes 2 ☐xNo	Specify:		Specify	Whit	e	
21215-0036	within 72 hours after death with the Maryland ene. than "netural" or items 23e or 28e-f show he Medical Evaminar must be notified at	Completed	15. Decedent's (Specify only highest		(Give	dent's Usual Occup	during most of work	ina	16b. Kind of Bu	siness/In	dustry	
7	ithin ne.	du	Elementary/Secondary (0-12)	College (1-4or	5+) life.	DO NOT use retired	1)					
2	lied v tygie her ti nt, in		12 17. Father's Name (First, Middle, L	act)	Exe	cutive	18. Mother's Nam	o /Cient Middle	Equifax (		Bureau	
anc	ntal h	Be	Thomas J. Seml	·						10)		
ž	d Mei d Mei nark	2	19a. Informant's Name/Relationsh		10h Meilli	a Address /Ctreet		on M. M		04-4- 7	0 (1)	
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 Is marked other than "netural", or items 23e or 28a-f show other treumatic event, the Medical Examinar must be notified at				19b. Maili	ig Address (Street i	and Number or Rur	ai noute ivuind	er, City or Town,	State, ZIL	(C008)	
	1 and Heali em 2		Boyd Brown / So 20a. Method of Disposition	n	20b. Place of Dispo	sition (Name of	Millino	Date M	20c. Location -		own State	
ğ	nt of nt of r. if it		1 ☑ Burial 2 ☐ Cremation		9 _	natory or other plac	June	e 1,	200, 2000, 101	only or th	, olalo	
altimore,	nit. Pe lartmen ortant: Injury		4 □ Donation 5 □ Other (Sp. 21. Signater of Funeral Service L		Post Cem			006	West Po	int,	New Y	ark
Ba Ba	permit. Pege Department of Important: if any Injury or		2 ams &	Ooder	F. 50	rancis J. 00 Univer	ss of Facility Sity Blvo	Funeral	l Home I ilver Sp	nc. ring	,MD 20	901
			23a. Part1. Enter the disease, or of shock, of heart failure. List of	complications that caus only one cause on each	ed the death. Do not ent line.	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximat Interval Bet	ween
,	Physician		Immediate Cause (Final disease or condition	ASPI	RATION	PAEUM	AINC				Onset and	
	/Medical Examiner		resulting in death)	7	s a consequence of):							
	LAGIIIIICI	s	Sequentially fiet conditions,		15PHAG11	+				ſ	אטאקן	15
	ed isit	Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence of):	Δ. –	- N	-AAFA hi	de:		YEAD	> <
_	and and	хап	that initiated events resulting in death) Last	c. Due to (or a	s a consequence of):	MUCHEI	mer D	Euren [	η-		Terre	->
8760,	icate be executed physicien and s the burial-transit				, , , , , , , , , , , , , , , , , , , ,							
687	icate phys	일		d								_
Box (	death certificate be executed e attending physicien and of for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom					23d Dat	e of delive	arv	
	death a atte	clai	in the past 12 months?			Ectopic pregnancy Other (specify)			Mor		*	Year
P.O.	that the de led by the a detached f	lsk	9 Unknown	9□ Unknown								
	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant condition	s contributing to death	but not resulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use contr	ibute to th	ne cause of c	death?
rds	w requires that s been signed t should be det	å g						1 🗆 '	Yes 2 No	3 🗌 Prob	ably 4 □l	Jnknown
S	s bee	Completed						24a. Was	an 24b. V	Vere auto	psy findings	available
Re	The law ste has l	E O							psy primed? d	rior to coi leath?	impletion of c	ause of
tal	an: tifice tor. p	BeC	25. Was case referred to medical				26. Place of Deat	1 Yes	,,	☐ Yes	2 No	
Division of Vital Records,	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ fnpat	ient 2 ER/Outpatien	t 3 DOA Othe			dence 6 □Othe	ar /Specifi	4)	
0	19 Ph ter th		27. Manner of Death	28a. Date of In	iury 28b. Time of ay Year) Injury				how injury occurr		·	
Ö	Attending r death. ector: After by the fune	atlo	1 Natural 5 Pending 2 Accident investiga	ation	ay / Sai/ Injury		Yes 2□No					
<u>Vis</u>	r Atte	ti e	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	and 289. Place of Ir	njury - At home, farm, str atc. (Specify)	eet, factory, office		28f. Location ( City or Tox	Street and Number	er or Rura	I Route Num	iber,
۵	Ital or irs afte rel Dir led in	Certification:										
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificete ha completely filled in by the funeral director, page	edical	(Check only 2   Medical E	xaminer: On the basis	t of my knowledge, death of examination and/or in	occurred at the time	ne, date and place, pinion, death occur	and due to the	cause(s) and mai	nner as st	ated.	:)
	To the within 2. To the Complete	Med	oney	and manner s	itated.							
	T V So		29b. Signature and titlerof certifier	0 4.0		29c. License			29d. Date signed	(Month,	uay, Year)	
	6(4)		CAMOUN	e. My			700		May 15	, 7	2006	)
	(2)		30. Name and address of person w	no completed cause of	death (Item 23a) (Type,	Print)	Willia	Luar Dos	7 M.N.	0.)	.00	
	Sta	te	31. Date filed (Month, Day, Year)	32. Regis	trar's Signature	V >1,	, voice, k	LINISHOK	., "			
	Registr	ar	MAY 19	2005	as It for	edi						

Direction 17 Base 172001

			1 - For State Ragistrar	State of M	aryland		rtment			ind M		giene Reg. No	006	176	48
ı	Physici		1. Decedent's Name (First, Middle, La EUGEN		r .	Six	ith				2. Date of Dea Month	Day	2 dear	3. Time of 1	Death M
	/Medio Examir		4a. Facility Name (If not institution, giv				4b. City, 1	Fown, or	Lusb		7147	4c. C	ounty of Death Calv	ert	
	Funeral Director		5. Social Security Number 218-14-3333 Usual Residence of Decedent	ex 7. Ag X M 2 ☐ F	e (In yrs. la. 82	st birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day Jun 22	, Year)	9. Birthp Coun	lace (State or try) laryland	Foreign
	Maryland a-f ahow	tor	10a. State 10b. County	vert	10c. City,	Town or Lo	cation		Lusb	у			1	0d. Inside City	
	with the	I Director	10e. Street and Number 1015 Coster Road				10f. Zip	Code	2065	7		10g. Citize	n of What Coun U.S.A	-	
920	within 72 hours after death with the Maryland liene. r than "naturel", or Items 23a or 28a-1 ahow the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married  Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1XYes 2 If Yes, Give Year or Dates:		3	Vas Decede Yes, speci		spanic Orig , Mexican Specity:	gin? (Spec , Puerto F	cify Yes or No- lican, etc.)		Race - Americ Black, White, o pecify: Black	etc.	
Maryland 21215-0036	d within piene. r then "	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 5		5+)	16a. Deced (Give life. L	kind of worl OO NOT use	k doné di e retired)	urina most		g	16b. Kind	of Business/Inc	,	
and	ould be filed Mental Hygi arked other atic avent, t	To Be C	17. Father's Name (First, Middle, Last	Nathan Earl S	mith				18. Molhei	r's Name	(First, Middle,	Maiden Si nette C			
Mary	and and	-	19a. Informant's Name/Relationship (	Type, Print)			g Address Coster I					r, City or T	own, State, Zip	Code)	
Baltimore,	Pages 1 and 2 nent of Health int: If Item 27 I		20a. Method of Disposition  1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		cer	ce of Dispos netery, crem John UM	atory or oti	her place	1	05/2		20c. Loca	tion - City or To Lusby,		
Balti	permit. Page Department of Important: If any injury of once.		21. Signature of Funeral Service Licer	Sewell	,	22	Name and Sew 145				d Prince F	rederic	k, MD 206	78	
	Physician /Medical Examiner	-10	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	plications that caused one cause one cause on each line.  a	he. La K a conseque	ence of):	an C		, such as o	cardiac or	respiratory arr	est,		Approximate Interval Betwo Onset and D	reen
8760,	the death certificate be executed y the attending physician and ched for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c.  Due to (or as											
.O. Box 6	the death certifiery the attending priched for use as	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant al 9 ☐ Unknown	2 Fetal d	leath 3 🗌	Ectopic pre Other (spe					230	d. Date of delive Month	•	ear .
rds, P	The law requires that te has been signed b age 2 should be deta	þ	Part II. Other significant conditions of	ontributing to death b	ut not result	ing in the un	derlying ca	use givei	n in Part I,			bacco use	contribute to the	e cause of de	
of Vital Records,		Completed					1				24a. Was a autops perform	sy .	death?	psy findings a apletion of ca 2 No	vailable use of
ſ Vit	Physician: 1 this certifical al director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatie	ent 2 🗆 El	R/Outpatient	3 DO/	Other		of Death	Check only on		Other (Specify	)	
Division of	Ter fler	atlon: T	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation		ry 2 y Year)	8b. Time of Injury		c. Injury Work		21	3d. Describe ho	·		/	
Divis	al or Att	Certification:	3 Suicide 6 Could not b 4 Homicide determined	280. Place of in	ury - At hom c. (Specify)	e, farm, stre	et, factory,	office		2	Bf. Location (SI City or Town		lumber or Rural	Route Numb	er,
	To the Hospital or Attendit within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medical Exar	ysician: To the best niner: On the basis o and manner st	f examınatic ated.	n and/or inv	estigation,	in my opi	inion, deatl	h occurre	d at the time, d	ate and pl	ace, and due to	the cause(s)	
	To the within 2 To the comple	W	29b. Signature and title of certifier	completed cause of a Rand S	-		29c.	DO 5	number 590	061	1	9d. Date s	igned (Month, E	pay, Year) 1200	6
	4+1		30. Name and address of person who 110 Hospital	Rand S	leath (Item 2	23a) (Type, 1	Print)	tun 1	tingi	tow.	n N	10	206	78	
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1	32. Registr	a Signatu	re /	Spe	the s							

			1 - State Registrar	State of Maryla		artment of H			ene (	06	17649
		\$	Decedent's Name (First, Middle, Last)					2. Date of Death Month		Voor	3. Time of Death
	Physici /Medio		Robert C. Schaeffe	er				May	4 -	2006	1:29 p <sup>M</sup>
	Examir		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or	Location of Death	1	4c. County	of Death	
		1	Anne Arundel Medic			Annar			Anne	Arun	
	Funeral Director		5. Social Security Number 6. Sex 1⊠	M 2□F 7. Age (In yrs	s, last birthday) <b>7</b>	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Apr. 5,	<sup>Year)</sup> 1939	_ Countr	ace (State or Foreign y) ylvania
			Usual Residence of Decedent					Apr. J,	1000	I CIIIIS	yrvania
	ehow	'n	10a. State 10b. County MD Anne Aru		Severr	ocation na Park				100	d. Inside City Limits 1 ☐ Yes 2 No
	289-1	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of	What Countr	
	3a or	I Dir	799 Dividing Road			211	46		g. Onizon or	USA	y:
-0036	s 1 and 2 should be filed within 72 hours effer death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23e or 28e-f ehow other treumatic event, If a Macical Exercital must be riviliad at	ed by Funeral	11. Marital Status  1 Never Married 2 X Married 3 Widowed 4 Divorced  15. Decedent's Educi	2. Was Decedent Ever in Armed Forces? 1. 25 Yes 2 □ No tf Yes, Give Year or Dates: Viet	nam	Was Decedent of Hi If Yes, specify Cubar 1  Yes 2 No	Specify:	o Rican, etc.)	Specify Specify		te. te
21215-0036	within 72 ane. than na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give	kind of work done a DO NOT use retired, Val Office	luring most of wor )	king	6b. Kind of B	Milita	
	ould be filed Mental Hygin arkad other atic event, II	To Be Co	17. Father's Name (First, Middle, Last) Richard Clark Schae	5+ effer				ne (First, Middle, M. Toan Fremo		ne)	
Maryland	id 2 should th and Men 27 is marks 17 is marks	-	19a. Informant's Name/Relationship (Type Brenda Schaeffer/W.	•		ng Address (Street a		ral Route Number, Severna	-		
Baltimore,	permit. Pages 1 and 2 Department of Health at Important: If Item 27 is eny injury or other treu once.		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 反 Re 4 □ Donation 5 □ Other (Specify)	moval from State	cemetery, crei	esition (Name of matory or other place	L ria	Date 2	0c. Location -	City or Tow	n, State
Balti	permit. Departm Importa- eny inju		21. Signature of Funeral Service Licensed		- 22 E	Name and Address & Sarranco & 95 Gov. R	s of Facility	.A. Seve	erna Pa	ark Fu	neral Home D 21146
8760,	Physician // Medical Examiner pural-transit	dicai Examiner	23a. Pañ1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a conse	equence of):	a-biom	lyo pa	ase		1	Approximate niterval Between Onset and Death Onset 4
P.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physicien and tage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	tal death 3[	Ectopic pregnancy Other (specify)				te of delivery	/ lay Year
	uires that signed b	þ	Part II. Other significant conditions cont	ributing to death but not re	sulting in the u	nderlying cause give	n in Part I.		cco use cont	ribute to the	cause of death?
Vital Records,		Completed						24a. Was an autopsy perform 1 Yes 2		Were autops prior to comp death? 1 \(\sum \text{ Yes}  2	sy findings available pletion of cause of
	sicia. certif recto	Be	25. Was case referred to medical examiner?	ospital: V.	7	the Othe	-	th Check only one			
ō	Phys r this ral di	. To	1 ☐ Yes 2 No  27. Magner of Death	1 Inpatient 2 ( 28a. Date of Injury	28b. Time of	IL 3L DOA	4   Nursing H	ome 5 Residen 28d. Describe how			
0	ding th. : After	tion	Natural 5 Pending investigation	(Month, Day Year)	Injury	Work	? ′es 2 ∐No		injury occur.		
Division of	if or Attending Physician: efter death. Director: After this certification by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury · At building, etc. (Spec	home, farm, str ufy)			28f. Location (Stre City or Town,		er or Rural F	Route Number,
	To the Hospital or Attendin within 24 hours effer death. To the Funerel Director: At completely filled in by the fur	edicai C	29a. Certifier (Check only one)  Certifying Physic Certifying Phys	cien: To the best of my kr er: On the basis of examin and manner stated.	nowledge, deatleation and/or in	n occurred at the tim vestigation, in my op	e, date and place, inion, death occur	and due to the cau rred at the time, dat	se(s) and ma e and place,	inner as state and due to th	ed. ne cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	\		29c. License	number	290	d. Date signed	d (Month, Da	ay, Year)
			) Jama k	un med		152	3148		06/14	106	<b>'</b>
			30. Name and address of person who con	npleted cause of death (Ite	m 23a) (Type,	Print) N. Ha	nı	Ь	5.00		20716
	e i i i i i i i i i i i i i i i i i i i		James W	, Koss	4175	14. Ha	nsou Ct	- Boo	n'e	MS	20716
,A	Sta Registr		31. Date filed (Month, Day, Year) 2006	Registrar's Sign	Nulle Mark	An I			,		

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			1 - For State Registrar	State of Maryla		tificate of			Reg. No.	0 0	11000
			Decedent's Neme (First, Middle, Las	0 1	<	-1-11-		2. Date of Dea		Yeer	3. Time of Death
	Physicia /Medic		Lucas .	Sands		2take	m		4 06		11:18 PM
	Examin		4a. Fecility Neme (If not institution, give	street and number)		4b. City, Town,	or Location of Deat	h	4c. County o		
				tospital		Cum		1	Alle	gan	4
	Funeral		5. Social Security Number   6. Se	7. Age (In yi ∑M 2□F	rs. last birthdey) Yrs.	If Under 1 Year Months Days	Hours Min.	(Month, De	h y, Yeer)	9. Birthpl Coun	leod (State or Foreign try)
	Director		N/A Usual Residence of Decedent		113.		33	05 24	06		mo.
	and **		10a. State 10b. County	10c.	City, Town or Lo	cation				10	0d. Inside City Limits
	Maryl f ehc	ō	PA Somo	rset S	alisbu						1 X Yes 2 □ No
	the 128a	Director	10e. Street and Number	1301	0.1300	10f. Zip Code	<u> </u>		10g. Citizen of W	hat Coun	try?
	3e or	٥	345 Wilhelm	Road		155	58		USA		
	deeth	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 13.		Hispanic Origin? (S oan, Mexican, Puerl	pecify Yes or No			an Indian,
ယ္	or ite	Fur	1 ☑ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No		1 Yes, specify Cut 1 ☐ Yes 2 🕱 No		o Rican, etc.)		, White,	etc.
93	ours a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		ILITES ZUNO	Specify:		Specify:	100	nite
21215-0036	filed within 72 hours after deeth with the Maryland Hygiene. ther than "netural", or ttems 23e or 28e-f ehow int, the Medical Examinar must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	dent's Usual Occu kind of work done	during most of wor	rking	16b. Kind of Bus	iness/inc	lustry
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2	filed with Hygiene other than		0		I I	nfant	10 Matheda Nos	no (Ciest Middle	Maiden Sumame		
Ē	be fill Ital H od otl	Be	17. Father's Name (First, Middle, Last)	1 64 1/						,	
3	2 should be and Mental is marked of sumatic eve	2	Jason Mich			- Add (C4	All ison			2 1	Codol
Maryland	12 st h and 7 ts n traun		19a. Informant's Name/Relationship (1				and wanteer or Ho				0
	1 and Health em 27 ither tr		Mother - All 20a. Method of Disposition		. Place of Dispo	sition (Name of	Inelm .	Date Date	20c. Location - C		o. 15558 wn. State
Baltimore,	o ← = 0		1 Burial 2 Cremation 3			natory or other pla	1			-	
Ë	permit. Page Department of Important: If any injury or once.	. 4	* 4 □ Donation 5 □ Other (Specify  21. Signature of uneral Service Licen				tory 05/2				
Ba	Departit. Departit Import Import Injury Inju		21. Signature of Juliaral Salvice Licent	7.							Home, P.A. 21502
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10	- sections:		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		o s	. 17				Interval Between Onset and Death
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	ntifica ng ph as th		IF FEMALE:								
Box	eath cert attending for use	an/h	23b. Was decedent pregnant	23c. If yes, outcome of pre-		Ectopic pregnanc	су		23d. Date		ry Day Year
	e dea he at hed fo	sici	in the past 12 months? 1 Yes 2 No	4 Pregnant at time of 9 Unknown	of death 5	Other (specify)			IVIOLI		Day
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of	Phys this al dir	-T	1 Yes 2 No	1 Dalinpatient 2		IL 3 DOA	4   Nursing F		dence 6 Other	1-1-7	")
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Δ	atter Dire	Certification:	4 Homicide	building, etc. (Spe	ecify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tox	vn, State)		
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,			ysician: To the best of my							
	n 24 h	Medical	(Check only 2 Medical Exam	niner: On the basis of exam and manner stated.	ination and/or in	vestigation, in my	opinion, death occu	urred at the time,	date and place, a	nd due to	the cause(s)
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: Completely filled in by the	ž	29b. Signature and little of certifier	1101			se number		29d. Date signed		
)	8		Hall Wi	21/1/11	7	H6:	3736		05/2	/20	26
	7. PA		30. Name and address of person who	complet - cause of death (	tem 23a) (Type,	Print)		•			
	nes		Dale Wolfor	d Do 6	00 me	moria	I Ave. S	suite:	302 Ci	imbe	2060 perland Md
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			1 - For State Registrar	State o	of Marylar			of Health a of Death	ınd Me		ene J. No.2 0 0 6	176	51
	Physici	an	Decedent's Name (First, Middle, Last	:)					2	2. Date of Death Month	Day Year	3. Time of I	Death
Т	/Medic		Eloise			inia		Seibert		May 27,	2006	9:45	P M
	Examin	er	4a. Facility Name (If not institution, give		ŕ		,	own, or Location of			4c. County of De		
			37 Somerville 5. Social Security Number 6. Se		7. Age (In yrs.	last hirthday)	If Under 1	umberland Year   If Under 2		I. Date of Birth	Allega	11 y irthplace (State or	Foreign
i.	Funeral Director			M 21∑∏ F	83	Yrs.	Months	Days Hours	Min.	(Month, Day, Y	'ear) (	aryland	roraign
	P .		Usual Residence of Decedent									· ·	
	show	r	10a. State 10b. County		10c. Ci	ty, Town or Lo		3				10d. Inside City	
	28a-1	Director	MD Alleg	any		Cui	nberla			100	. Citizen of What (		
	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or liems 23a or 28a-f show imatic event, it a Marical Exam ar must be collised at		37 Somervill	e Aven	ue		TOI. Zip C	215	02	100	USA	ountry:	
	ms 2:	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	I.S. 13.	Vas Decede	ent of Hispanic Orig	in? (Speci	fy Yes or No-	14. Race - Ал		
٥	or Its	/ Fui	1 Never Married 2 Married	Armed Fe 1 ☐ Yes If Yes, Gi	2 X No	1	i res, specii I∐ Yes 21	fy Cuban, Mexican,  ☑ No Specify:	Puerto Ri	can, etc.)	Black, Wh	ite, etc.	
9500-61212	ural',	d by	3 X Widowed 4 □ Divorced	Year or E	Dates:							White	
۲ ک	n 72 t	Completed	15. Decedent's Edu (Specify only highest grad	de completed)		(Give	lent's Usual kind of work DO NOT use	Occupation of done during most a retired)	of working	, 16	6b. Kind of Busines	s/Industry	
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ַ	other other	BeC	17. Father's Name (First, Middle, Last)			1 ayı	011 0		r's Name (	First, Middle, Ma		Rapper	
<u>a</u>	should by	ToE	Frank Les	ter		Wilso	n	LaV	Vera		L	ovenstei	n
Maryland	2 sho		19a. Informant's Name/Relationship (T)				-	Street and Number			•		
_	ss 1 and 2 should k of Health and Ment (Itam 27 is marked r other traumatic e		Charles L. Seibe:	rt / so		3 / Place of Dispo		ville Ave	enue,	-	Land, MD		
saltimore,	permit. Pages Department of I Important: If Its any Injury or o		1 ∏ Burial 2 ☐ Cremation 3 ☐ 6 4 ☐ Donation 5 ☐ Other (Specify)		State	cemetery, cren	natory or oth	ner place)		1			
	entme crtan crtan njury		21. Signature of Puneral Service Licens		Sui			1 Park   0 Address of Facility		_			P.A.
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	Physician /Medical Examiner	ılner	resulting in deality	a. <u>Chro</u> Due to	each line.	tructiv	ve Pul	Lmonary D			,	Approximate Interval Betwonset and Dispersion Dispersio	eath ars
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Ţ.	res that tigned by	y Ph	Part II. Other significent conditions co	ntributin <b>g</b> to c	leath but not res	ulting in the ur	iderlying cau	use given in Part I.		23e. Did tobac	cco use contribute	to the cause of de	ath?
202	w requires been sign should be	ed by								1 1 Yes	2 □ No 3 □ F	robably 4 🗆 Ur	nknown
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Vital	Physician: The this certificete rat director, pag	Be (	25. Was case referred to medical examiner?						of Death /	Check only one			
5	Physic this c	မ	10,105 219,140			ER/Outpatien					ce 6 □Other (Sp	ecify)	
	ding f h. After funer	tlon:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date (Mor	of Injury nth, Day Year)	28b. Time of Injury	M 286	c. Injury at Work? 1 ☐ Yes 2 ☐ N		d. Describe how	injury occurred		
DIVISION	To the Hospital or Attanding I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	289. Place	e of Injury - At hi ling, etc. (Specif	ome, farm, stre				f. Location (Stree City or Town, S	et and Number or F State)	lural Route Numb	Θ <i>r</i> ,
	Hospital 24 hours a Funeral I	Medical	29a. Certifier 1 ☐ Certifying Phy (Check only one)	iner: On the b	e best of my kno pasis of examina oner stated.	owledge, death	occurred at estigation, in	t the time, date and n my opinion, death	place, and occurred	d due to the caus at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)	
	To the within 2 To the complet	Me	29b. Signal was and title of certifier	1			29c.	License number		29d	. Date signed (Mor	th, Day, Year)	
	1		111/1/4	lans	U			D16041			May 30,	2006	
	nio		30. Name and addre — f person who co	ompleted cau	se of death (Item	п 23а) (Туре,	Print)			1			- 45
	nes		Terry E. Wil				moria	1 Avenue,	, Cum	berland,	MD 215	02	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 9 2006	1 P.A .	Registrar's Signa	nure for	M.						

State of Maryland / Department of Health and Mental Hygiene. - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician May Louise 18 2006 Beatrice Turner 10:01A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 XX Yrs. 579-12-8630 July 9,1921 Maryland Director 84 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f sho other traumatic event, It e Madical Examinar raist be notified at 1 1 Yes 2 □ No Washington, D.C. None None Directo 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 3410 Carpenter St. S.E. 20020 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any injury or other traumatic event, the Mentals of 1000. Black, White, etc. 1 ☐ Yes 2 TNo If Yes, Give X Year or Dates: 1 Never Married 20 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Norman Shriver Lacy Lowman ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Richard Carroll Turner/Husband S.E. Wash.D.C. 20020 20c. Location - City or Town, State 3410 Carpenter St. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cem. 5/23/06 Suitland, MD. \* 4 ☐ Donayon 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 20745 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 4hm **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 9 2 No 3 Probably 4 Unknown 1 Tes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 1 10 24a. Was an certificate has autopsy performed pert 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 PER/Outpatient Certification: To 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 ANatural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours after To the Funeral Dire 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 5/18/06 reng MO 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Journ Conter JULIEL. DOURN, MP 108015 P. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 6 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** р м Tran Quy T. 5:40 May 16 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sacred Heart Home Hyattsville Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours 1 M 2K F 95 213-06-4065 1910 North Vietnam Director July 1, Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location d other than "naturel", or itams 23a or 28a-f show event, the Medical Expressional to continue at 1 ☐ Yes 2 X No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 1637 Featherwood Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Speciasian δ 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked Thien Tran Ngo Doan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health if item 27 i Ngoc T. Le/ Granddaughter 1637 Featherwood Street, Silver Spring, MD 20904 un or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 19, permit. Page Department of Important: if eny injudy of once. Gate of Heaven Cemetery 2006 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Francis J. Collins Funeral Home Inc. Willia 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Hypertensive Cardiovascular Disease /Medical Due to (or as a consequence of). Examiner Coronary Artery Disease Seventially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical as the 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, been signe should be Progressive Cognitive Decline 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2€ No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 🛣 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be 3 Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 ☆ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D51122 May 17, 2006 Ne Print) Providence Hospital 1160 Varnum St., NE, Washington, Dc 20017 30. Name and address of person wind completed cause of death (Item 23a) (Type, Print) Juanitez, MD Esmerando 32 Registrar's Signature State Registrar

Isandino Perfecto Ramirez-Velazquez

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

			For State Ce	ertificate of	Death		Reg	No. 20	106 1765
Phy ledical Ex	sicia tamir	n/	Decedent's Name (First, Middle, Last) Isandino Perfecto Ram	to Ramirez	z-Velasquez <del>Velazqu</del>	2	2. Date of Death Month May 22, 20		3. Time of Death 1658 hrs
			la Facility Name (if not institution, give street and number)  13 South Higgins Street	4	b. City, Town, or L Easton	ocation of Death	_	4c. County of I	
Fund Direct			S. Social Security Number 6. Sex 7. Age (In yrs 1 M 2 F	last birthday) Yrs.	If Under 1 Year  Months Days	If Under 24Hrs. Hours Min.	-		9. Birthplace (State or Greigh Gitatte Mala
	28a-f show any 1 at once.	50	MD Talbot F	ty, Town or Location	on 10f. Zip Code		100	g. Citizen of What	10d Inside City Limits 1 Yes 2 X No Country?
vith the Ma	s 23a or 28 e notified		204 North Aurora St.Apt 1	U.S. 13. Was	2160 Decedent of Hisp	panic Origin? ( Spe			American Indian, Black,
after death v	al", or item ner must b	by Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year or Dates.	1 X	Yes 2 No	Guatema specify:	lan ——	White, e	White
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MD 21 d 2 should Ith and Me	tem 27 is ma traumatic ev		iga Informant's Name/Relationship (Type, Print) brothel Mauro Ramirez Velazquez/	204		urora S	St Apt.	1 East	on,Md21601
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Baltimo permit Page Department	Important: injury or of		21. Signature of Funeral Service Librasee	92	41 Colu	ımbia B	lvd.Si]	lver Sp	VICE, P.A. ring, Md20910
Physic /Med Exam	ical		23a. Part I. Enfer the disease, or complications that caused the dea failure. List only one cause on each line  Immediate Cause (Final disease or condition resulting in death)  a Chronic alcohologous disease or condition resulting in death)	lism	ne mode of dying,	such as cardiac or	respiratory arres	st, snock, or neart	Approximate Interval Between Onset and Death
		aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	e of):					
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	physician and he burial - tra	edical	X UNPENDED AMENDED ITEM#1	,23a,27,pei	nue,g800,0,	/14/05 t1			
<b>5x 68760,</b> ath certificate be	the attending phys hed for use as the b	cian/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown 1 Dispersion 1	2 Fet	tal death 3 [	Ectopic pregna	ncy	23d Date of de Month	elivery Day Year
P.O. Box	signed by the a	by Physi	Part II. Other significant conditions contributing to death but no	ot resulting in the u	inderlying cause g	iven in Part I.			ute to the cause of death?  Probably 4 V Unknown
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	certificate ector, page		25. Was case referred to medical			of Death (Check of	Aug		2 100 2 100
Vita	d: bi	o Be	examiner?  1 V Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient	3 DOA	Other Nursin	g Home 5 F	Residence 6 🗸	Other Scene
n of	After	on: T	27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day, Year)	28b. Time of Ir		y at Work? 'es 2 No	28d Describe h	ow injury occurred	3
Division of Vital   Hospital or Attending Physician: 24 hours after death	To the Funeral Director: completely filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	t home, farm, stree	et, factory, office b	uilding, etc.	28f. Location (S or Town, St		or Rural Route Number, City
To the Hospi within 24 hou	To the Funer completely fil	Medical Co	29a. Certifler 1 Certifying Physician: To the best of my knowl (Check only 2 Medical Examiner: On the basis of examination and manner stated	edge, death occur n and/or investigat	red at the time, da	ate and place, and , death occurred a	due to the cause t the time, date a	e(s) and manner a	s started e to the cause(s)
± 3	L S	Me	299. Signature and title of certifier		29c. Licens O.C.I			29d Date signed May 23, 200	(Month, Day, Year)
	2		30. Name and address of person who completed cause of death (II Laron Locke MD. Assistant Medical Examine		Street, Baltir		l 01		
	S Regis	tate	31. Date filed (MorthAY 37) 2006 32 egistrar's Sign						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician**  $p^{M}$ Arthur B. Wells May 2006 4:56 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months MM 2 F Director 577-14-7982 89 April 7, Washington, DC Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-f show Examiner must be notified at 1 ☐ Yes 2 X No Silver Spring Maryland Montgomery Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö HSA Iteme 23a 20902 2427 Eccleston Street death Funera permit. Pages 1 and 2 should be filed within 72 hours after dea. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nation of the permitted of 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 → No Specify: Specify White Completed by 3 Widowed 4 Divorced WII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Economist Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Etta Unknown Roger Clark Wells 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2427 Eccleston Street, Silver Spring, MD 20902 Kathryn Elizabeth Wells/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State May 18, 1 ☐ Burial 2x Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2006 Alexandria, Virginia Metropolitan Crematory 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Cardiac Arrest /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Dis assert injury) that initiated events resulting in death) Last Due to (or as a consequence of): Examine ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown ete hes been signed | page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2√√ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No certificete Division of Vital 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ R/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ih: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 ⊊Natural 2 ☐ Accident 5 Pending s after dec. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide illed in within 24 hours a To the Funeral I Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 /a Confflor Medical (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D59373 au May 17, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dawn Marie Christerson, M.D. 10301 Georgia Avenue, #203, Silver Spring, MD 20902

Registrar

State

31. Date filed (Month, Day, Year)

18

2006

32 Registrar's Signature

		•	For State Registrar	State of Mary		artment of tificate o		Mental Hy	/giene Reg. No.	06	17656
	Physici		1. Decedent's Name (First, Middle, Las	st)				2. Date of D Month	Day	Year	3. Time of Death
	/Medic		ELIZABETH TALLEY					MAY		2006	10:31A M
33	Examin	er	4a. Facility Name (If not institution, give			//	i, or Location of De LINTON	ath	4c. County		EORGES
			SOUTHERN MARYLAN  5. Social Security Number 6. S		yrs. last birthday)	If Under 1 Ye			rth		ace (State or Foreign
	Funeral Director		249 42 8593	□м ХХТ	77 Yrs.	Months Day	s Hours Mi	n.   (Month, D	ay, Year) 4, 1928	Count	CAROLINA
	ס		Usual Residence of Decedent								
	anylar show	_	10a. State 10b. County		c. City, Town or Lo					10	od. Inside City Limits  1XXYes 2 □ No
	Sa-f	Director	MD PRINCE G	EURGES	BRANDYWIN				10- Cisin-n of h	1/5-1-0	
	with t	Ö	10e. Street and Number 12006 WARDELL WA	v		10f. Zip Cod 206			10g. Citizen of \		•
	na 23	erai	11. Marital Status	12. Was Decedent Ever	in U.S. 13. \	Was Decedent of	of Hispanic Origin?	(Specify Yes or N		e - America	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural; or itema 23a or 28a-f show amy injury or other traumatic event, the Medical Examble mutal be mailled at ance.	by Funerail	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	1	fYes, specify C 1 □ Yes X2X i	uban, Mexican, Pue	erto Rican, etc.)	Specify	k, White, e	itc.
Ö	72 ho	Completed	15. Decedent's Ec		16a. Deced	dent's Usual Oc	cupation ne during most of w	rorkina	16b. Kind of B	usiness/Ind	ustry
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Maryland	ntal H	Be	17. Father's Name (First, Middle, Last) CHARLES TALLEY					ame <i>(First, Middle</i> RIESTLEY	s, Malden Suman	18)	
2	d Me mark matic	<b>1</b>	19a. Informant's Name/Relationship (	Tyne Print)	19b Mailir	ng Address (Stre	eet and Number or i		per. City or Town	State Zin	Code)
Σ	nd 2 s lith an 27 is r trau		KATHLEEN DRAKE R		Ŷ.	•					,
ē,	f Healten		20a. Method of Disposition	2	0b. Place of Dispo		1	Date	20c. Location -		wn, State
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			23a. Part1. Enter the disease, or com shock, o heart failure. List only	plications that caused the one cause on each line.	death. Do not ent			ac or respiratory a	arrest,	i	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a UEMOI	MUAGIC	: Sno	ch				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co							
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Вох	The law requires thet the death certifi sie hes been signed by the attending page 2 should be delached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of printing 1 Live birth 2		Ectopic pregna	ncy		23d. Da	te of deliver	y Day Year
O. E.	e dea the at hed fo	sici	1 Yes 2 XNo	4☐Pregnant at time 9☐Unknown		Other (specify,			1410	nui i	Jay 18ai
P.O.	het th id by detach	Phy	Part II. Dther significant conditions of	ontributing to death but no	ot resulting in the u	nderlying cause	given in Part I	23e Did	tobacco use cont	ribute to the	a cause of death?
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<u> </u>	Physician: r this certificanal director,	0 B	examiner? 1 ☐ Yes 2 🔼 No	Hospital:	2 ER/Outpatien	t 3 DOA	Othor	Home 5 Res		er (Specify)	)
Division of Vital Records,	o Ph	T.	27. Manner of Death	28a. D te of Injury (Month, Day Ye	ar) 28b. Time of	28c. lr	njury at Vork?		how injury occur		
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<u>≅</u>	or Atterder de Directo	Certification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, str	eet, factory, offi	ce		(Street and Numb wn, State)	er or Rural	Route Number,
	urs al		One Continue					1			
	To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificete he completely filled in by the funeral director, page	edicai	29a. Certifier 1 Certifying Ph (Check only 2 Medigal Exar	nysician: To the best of my niner: On the basis of exa and manner stated.	y knowledge, death imination and/or in	n occurred at the vestigation, in m	time, date and pla ly opinion, death oc	ce, and due to the curred at the time	cause(s) and ma date and place,	and due to	ited. the cause(s)
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	- S - Ö		) (lik)	- My		1 9	53885		(Ma)	2006	
0	(10)		30. Name and address of person who VENICAT - S - (31. Date filed (Month, Day, Year)	completed cause of death	(Item 23a) (Type,	Print)		[] 2 -	7/		0 000
_	V		VENKAT-S- K	Ammon	7501 SU	MUMATI	s (WA)	# 507	Chron	, M	10785
3	Sta Registi		31. Date filed (Month, Day, Year)  MAY 1 9 2006		Signature-	ki					

			For State Registrar	State of	Maryland / D	•	tment of H		Mental H	ygiei Reg.	/ 11111	5 17657
			Decedent's Name (First, Middle, Last)						2. Date of I	Death		3. Time of Death
	Physicia		Howard W	1. Wa	lsh				May	17,	2006 Yee	5:47P M
	/Medic Examin		4a. Facility Name (If not institution, give str			4	4b. City, Town, or	r Location of Dea			4c. County of De	eath
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	Funeral			M 2□F	7. Age (In yrs. last birt		If Under 1 Year Months Days	If Under 24 Hr	8. Date of E	Birth	9. E	hirthplace (State or Foreign Country)
	Director		185–18–0527	/ 2□F	87	Yrs.	Months Days	Hours Will	(Month, 5/3/	1919	Pe	nnsylvania
	2		Usual Residence of Decedent		10c. City, Town		41					10d. Inside City Limits
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	er de	Funerai	11. Marital Status 1 ☐ Never Married 2 ☒ Married	Armed For	ces? 2□No Retire	l If Y	res, specify Cuba	an, Mexican, Pue	to Rican, etc.)		Black, W	hite, etc.
36	rs aft	by F	3 Widowed 4 Divorced	If Yes, Give	e ites: 1967	10	☐Yes 2XXVQ	Specify:			Specify: W	hite
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<u> </u>	Ment Ment arke	٩	Harry Clarence Wal						Myrt1e			-
a	2 shi and Is m		19a. Informant's Name/Relationship (Type					and Number or F				a, Zip Code)
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tim	t. Pa ntmen ntant: njury		4 Donation 5 Other (Specify)		Kalas		matory	ss of Facility Ge	-		lgewater	
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or Iteme 23a or 28a-f ehow eny injury or other traumatic event, it a Medical Examinar must be notified at once.		21. Signature Funeral Service Licensee	1. h				Hill Rd				
			23a. Part1. Enter the disease, or domplica	ations that ca	aused the death. Do r						.,	Approximate
			shock, or heart failure. List only one tmmediate Cause (Final	cause on ea	ach line.			dise				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		chemic or as a consequence		ear i	01136	-95E			20 years
7	Examiner			Due to (	or as a consequence (	01).						
5:470		ler	Sequentially list conditions, b. if any, leading to immediate	Due to (	or as a cuitsequelice	of):						
U)	outed d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.									
00	en ar		resulting in death) Last	Due to (	or as a consequence	of):						
H-06	eath certificate be executed attending physicien and for use as the burial-transit	dicai	d.									
9	artifica ing pt	Med	IF FEMALE:									
5-1 Box	ath ce ttendi or use	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live bi	come of pregnancy inth 2  Fetal death		ctopic pregnancy	1			23d. Date of Month	delivery Day Year
	b e be	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregna 9⊟Unkno	ant at time of death own	5 🗆 (	Other (specify) _			-		
- A G	hat the ad by detac		Part II. Other significant conditions conti	ributina to de	eath but not resulting in	n the und	leriving cause giv	en in Part I.	23e. Di	d tobac	o use contribute	to the cause of death?
ds,	signe d be	d by	Prostate	Car					1[	Yes	2 No 3	Probably 4 Unknown
3 9	v requ been shouk	etec	Eno stag	a K	dney d	150			24a. W	ne an	24h Were	autoney findings available
Rec	ne lav s has ge 2	Completed	Znv 37ag	E 10.	They Do		-ASC		au pe	topsy rformed	? death	autopsy findings available to completion of cause of ?
3 E	vicien: The lav certificete has rector, page 2	မ င	25. Was case referred to medical				-	20 Place of D	1 Tes		No 1□Y	es 2 No
	Physicien: this certific ral director,	8	eyaminer?	spitat:	npatient 2 KER/Ou	dostient	3□ DOA Oth	00	eath Check on		e 6 ☐Other (S	anciful
2 4	g Phya er this eral dii	n: To	27. Manner of Death		of Injury 28b. 1	Time of	28c. Injur				njury occurred	роспу
io	Attending Frideath. ector: After by the funer	atio	1 Accident 5 Pending 2 Accident investigation	(MOIII	n, Day rear)	njury		Yes 2 □No				
vis 🖔	l or Attendi after deeth. Director: A I in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Ptace	of tnjury - At home, fang, etc. (Specify)	ırm, stree	et, factory, office		28f. Location City or			Rural Route Number,
	tal or Ars after el Dire	Cer			ingli oto. (opcony)							
HOWOUND WINIAM WOUSH	To the Hospital or Attending Physicien: The law requir within 24 hours after deeth.  To the Funeral Director: After this certificate has been s' completely filled in by the funeral director, page 2 should	edicai	25a Gentiler 1 Certifying Physic (Check only one) 2 Medical Examine	er: On the ba	bast of my knowledge asis of examination an ner stated.	a death : id/or inve	stigation, in my o	ne data and plac pinion, death oc	e, and the to the time	na caus le, date	e(s) and manner and place, and o	as stated fue to the cause(s)
1	o the	Me	29b. Signature and title of certifier				29c. Licens	e number		29d.	Date signed (Mo	onth, Day, Year)
	- S F O			/	mo		0	35103		M	ay 18	2006
00	- (11)		30. Name and address of person who con	creted caus	e of death (ttem 23a)	(Type, Pi	rint)			-		
4	(1)		Stephen Va 31. Date filed (Month, Day, Year)	ccar	c 224	620	10 Mo	ntrosc	Road	! R	ockvill	e Maryland
	Sta			P. R.	egistrar's Signature	Real .	<b>*</b> •					e Maryland
	Registr	al.	MAY 1 9 2006		40 0 1	100						

DHMH 17 Rev 1/2001

			1 - For Stata Registrar	State of Ma	ryland		artmen <i>tificat</i>			and Me		giene 2	006	176	58
	Physici /Medio		1. Decedent's Name (First, Middle, La Daniel J. Wol	•							2. Date of Dea Month May	Day	2006	3. Time of De 1:05 p	eath M
	Examin		4a. Facility Name (If not institution, given Anne Arundel Med	•			4b. City,		Location of			4c. Cou	inty of Death Anne	Arundel	
26	Funeral Director	9	5. Social Security Number 6. S 505–40–8569	ex 7. Age MA 2 F	(In yrs. last	t birthday) Yrs.	If Under Months		If Under 2 Hours	Min.	8. Date of Birt (Month, Da May 11	y, Year)	Cou	place (State or Fo	oreign
III.=3	death with the Maryland me 23s or 28s-f ehow r must be notified at	tor	Usual Residence of Decedent  10a. State 10b. County  MD Anne A	rundel	10c. City, T	own or Lo		Annar	∞lis					10d. Inside City L	
	or 28a	Director	10e. Street and Number				10f. Zip					10g. Citizen		•	
0000	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. If the marked other then "natural", or Iteme 23a or 28a-f show other traumatic event, the Medical Examinar most be notified at	by Funeral	736 Holly Drive  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☑ Yes 2 □ N If Yes, Give Year or Dates:			Was Deced f Yes, spec l □ Yes			gin? (Spec i, Puerto F	cify Yes or No- tican, etc.)		Race - Ameri Black, White,		
0-61717	id within 72 ho giene. or then "natur , the Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5- 4		6a. Deced (Give life. L	lent's Usua kind of wo DO NOT us Rear	rk done d se retired)	uring most	of workin	9	16b. Kind o	f Business/Ir	avy	
/iand	uld be file Mental Hy srked oth	To Be (	17. Father's Name (First, Middle, Last, Albin Wolkensdorfe					and the second			(First, Middle, Simmin		name)		
Mar	nd 2 sho ath and I 27 is me r traums		19a. Informant's Name/Relationship (Carolyn M. Wolken:				-				Route Numbe	-	wn, State, Zij 409	Code)	
more,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		20a. Method of Disposition  1 XBuriał 2 Cremation 3 4 Donation 5 Other (Specif		сет	e of Dispo- etery, cren	sition (Nar	ne of ther place	)	W-19-01-15	20,	20c. Location	on - City or Tongton,		
Dalillino	permit. Departn Imports Any injt		21. Signature of Eugeral Service Licer	Alla		Ba 49	Name and Price of Section 1975 Go	d Address CO & V. Ri	Sons Ltchie	, P.F		erna Pa erna Pa	ırk Fu ırk, M	neral Ho 21146	me
	Physician /Medical Examiner put	Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to turnodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	plications that caused one cause on each line  a. Due to (br as a b. Due to or a a c. Due to (or as a	consequent	ice of):				cardiac or	respiratory ar	rest,		Approximate Interval Betwee Onset and Dea	en th
J. BOX 66/6U,	The law requires that the death certificate be executed site has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at the 9 Unknown	f pregnancy	y eath 3□	Ectopic pr						Date of delive	ery Day Year	
us, r.	luires that the signed by ald be detacted.		Part II. Other significant conditions of the Charles Ohyte.			-			n in Part I.			obacco use c		he cause of death	
necords,	The law rec ete has bee page 2 shou	Completed by									24a. Was autop	SV	b. Were auto prior to co death? 1 \( \sum \text{Yes}	opsy findings avai impletion of cause 2 No	ılable e of
N II d	sician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:				Othe			Check only or				
INISION OF	To the Hospital or Attending Physician: The law within 24 butus after death, within 24 butus after death. To the Funeral Director: Attenthis centificate has a completely filled in by the funeral director, page 2.	ation: To	1 Yes 2 No  27 Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		Outpatien b. Time of Injury		8c. Injury Work	4 🗀 1401	21	e 5 Resid			(y)	
	tal or Atters safter desal Directored in by the	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Injurbuilding, etc.	y - At home (Specify)	, farm, stre	eet, factory	, office		20	8f. Location (S City or Tow	itreet and Nu n, State)	mber or Rura	al Route Number,	
	Hospi     24 hou     Funer letely fill	edicai	29a. Certifier Certifying Phone 2 Medical Example 2	nysician: To the best of miner: On the basis of and manner stat	examination	dge, death and/or inv	occurred estigation	at the time in my op	e, date and inion, deat	d place, ar	nd due to the d d at the time, d	cause(s) and date and plac	manner as s e, and due to	tated. the cause(s)	
	To the withing To the comp	Me	29b. Signature and title of certifier	2/25_				License		5		29d. Date sig			
			30. Name no ddress of person who 2008 D. Donal	completed cause of de	ath (Item 23	Ba) (Type, ا	Print)	N.	2/6	i G	tag Lee-	Llacer	n //		
	Sta Registr		31. Date filed (Month, Day, Year)	32 Segistrat	's Signature	1	och	)							

06-03663 Amos Weiskopf

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Physician Projection Physician Projection Physician Projection Physician Project Phy		1- For State Registrar	Certificate of Dea	ath	Reg No.	200	6 1765
As Facility Name (if not institution, give street and number)  Upper Chesapeask Medical Center  Be LAr   car Examine	Decedent's Name (First, Middle,Last)	WED WEDTOWN	ļ <sup>—</sup>	Month Day	Year		
Upper Chesapeake Medical Center   Bel Air   Harford   Social Society Number   Social Social Society Number   Social Social Society Number   Social Society Social Social Social Social Social Social Social Social Society Social						: County of Death	1030 1115
Usual Residence of Decedent    Street   1	1			l Air	٢	Harford	
State   The Stat			Mon			Foreigi	n'
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death of the cause of t	Box death c ie atten if for us	1 Yes 2 No 9 Unknown 9 Unknown	o Uther (St	pecify)			
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25 Was case referred to medical examiner?  1 Ves 2 No  25 Was case referred to medical examiner?  1 Ves 2 No  1 No	/ital	examiner? Hospital:	Inpatient 2 ✓ ER/Outpatient 3	Other:		ence 6 Other:	
28a Date of Injury  Subject pedestrian struck by vehicle	of \officers	27 Manner of Death 28a Da	te of Injury (tb, Day,Year) 28b. Time of Injury	I S			phicle
To be set of the control of the cont	Sion strendi death ctor:	Natural 5 Pending May 2  Accident Investigation May 2	9, 2006 1610 hrs	1 Yes 2 V No			
O under the control of the control o	Divis al or A s after al Dire ed in b	3 Suicide 6 Could not be determined (Speci			or Town, State)		
in a bail of the first the	hou hou	29a Certifier	· · · · · · · · · · · · · · · · · · ·	<b>_</b>			
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	= 4 = 9 6	one) 2 Medical Examiner: On the bas and manne	r stated.		he time, date and pla	ace, and due to the	cause(s)
29b. Signature and title of certifier 29c License number 29d Date signed (Month, Day, Year)	Fo the II within 24 Fo the Fu						th, Day, Year)
( hoder Me Fett mes)	Division of Vital R  To the Hospital or Attending Physician: within 24 hours after dealth To the Funeral Director: After this certific completely filled in by the funeral director.  Madical Certification: To Be C	29b. Signature and title of certifier		OCME	1 10/101	/ 30 2006	
	To the II within 24 To the Fi completel	Thospulle High	uise of death (Item 23e)	O.C.M.E.	May	7 30, 2006	
State 31. Date filed (Month, Day, Year) 2006 32 Registrar's Signature	To the II within 24 To the Fi completel	30, Name and address of person who completed a	ause of death (Item 23a) edical Examiner 111 Penn St			7 30, 2006	

State of Maryland / Department of Health and Mental Hygiene 11 [16] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Kun Yu /Medical May 10. 2006 8:15 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4007 Southend Road Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Min. **★** M 2 F Months Days Hours Director 215 31 5554 China Feb. 3, 1924 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location Items 23a or 28a-f ehow 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Montgomery Rockville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4007 Southend Road death Funeral 20853 China 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after ☐Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 Yes 2 No Specify: þ If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Specify: Asian "natural", Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Importent: if item 27 is marked other ti any Injuges other treumatic event, In-ping. 11 Tailor Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Yuen Yu Heung Chui Chow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kwai L. Yu / Son 4007 Southene Road Rockville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Gate of Heaven Cem. 5/20/2006 Silver Spring, Maryland 22. Name and Address of Facility Hines Rinaldi Funeral Home 21. Signature of Funeral Service Livensee Da 11800 New Hampshire Ave Silver Spring, MD 20904 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Colon Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospitel or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Be Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Diabetes Melitis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy performed? 1 ☐ Yes 2 \ No 2**₹**□ No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ZONo Certification: To Pis 28a. Date of Injury (Month, Day Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death.
Director: Aft investigation 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospitel within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D27865 May 16, 2006 Z Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark Li, M.D. 1721 University Blvd West Silver Spring, Maryland 32. Fegistrar's Signature 31. Date filed (Month, Day, Year) 8 State 2006 TRANS Registrar

			For State Registrar	State of Ma	ryland /	Department of F Certificate of		ental Hygie Reg		1/661
	- · · ·		1. Decedent's Name (First, Middle	e, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		BARBARA B	. ALEXANDER	3			-	01 2006	2057 M
	Examin		4a. Facility Name (If not institution	n, give street and number)		4b. City, Town, o	r Location of Death		4c. County of Deat	n
			UNION MEMORI			10 4 4 4	TIMORE		N/A	
П	Funeral	4	5. Social Security Number	6. Sex 7. Age	(In yrs. last bi	rthday) If Under 1 Year Months Days	Hours Min.	3. Date of Birth (Month, Day, Y	'ear) Co	nplace (State or Foreign untry)
	Director		212 36 9581 Usual Residence of Decedent	X	68	TIS.		APR.29	,1938 M	ARYLAND
	pue *		10a. State 10b. County		10c. City, Tov	vn or Location				10d. Inside City Limits
	Many!	៦	MD.	N/A		BALTIMORE				1☐,Yes 2☐No
	28a the	Director	10e. Street and Number	N/A		10f. Zip Code		10g	. Citizen of What Co	untry?
	Se or	₫	706 E.43#RD	ST.		212	L8	1	USA.	
	ma 2	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Decedent of I	Hispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No-	14. Race - Ame Black, White	
936	s 1 and 2 should be filed within 72 hours effer deeth with the Maryland f Health and Meniel Hyglene. Itam 27 is marked other than "natural", or Itama 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at	줍	1 Never Married 2 Mar 3 Widowed 4 Divorced	ied 1 ☐ Yes 2 🛣 N	o	1 ☐ Yes 2 ☒ No	Specify:	iouri, otory		LACK
21215-003	2 ho	Completed	15. Deceder	t's Education st grade completed)	168	Decedent's Usual Occup (Give kind of work done	pation	16	b. Kind of Business/	Industry
7	thin y	힏	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. DO NOT use retire	d)			
N	filed wi Hyglen other th	5	12TH		I PA	RA PROFESS				CITY SCH.
ב	avan de fi	9	17. Father's Name (First, Middle,	Last)			18. Mother's Name		iden Sumame)	
<u>X</u>	should be ind Mentel ind Mentel is markad umatic av	မ	UNKNOWN				PAULINE			V- Oo do l
Maryiand	2 sh send term		19a. Informant's Name/Relations			b. Mailing Address (Street	l Homewoc			
	s 1 end 2 of Health Itam 27 i		SHANTELL ALE	XANDER/GRAI	ND DAU	IGHTER 192. of Disposition (Name of	Da Da		c. Location - City or	
Baitimore,	Peges 1 nent of 1- int: If Ita iry or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		cemete	ary, crematory or other pla	ce)		BALTO, MD	
<u>=</u>	rtmer rtant nlury		' 4 ☐ Donation 5 ☐ Other (S	n H-	MT. Z	ION CEM.				
Ba	permit. Peges Depertment of Important: If it any injury or once.	4	2 Semelalis	will for	uace		S. SCRUGG			21213
			23a. Part1. Enter the disease, o	complications that caused only one cause on each lin	the deeth. Do	not enter the mode of dy	ng, such as cardiac or	respiratory arres	t.	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Coro		Arte	ru Di	Sease	٠, د	Onset and Death
ř	/Medical		resulting in death)	Due to (or as a		of):				
	Examiner		Sequentially list conditions,	b						
	<u>و</u> و	<u>ē</u>	if any, leading to immediate	Due to (or as a	consequence	of):			- 1	
	end end -tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	CONSEQUENCE	of):				
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587		edical		0.						-
×	certi	Š	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of del	very
Вох	es that the daath certifi Igned by the ettending be deteched for use et	Physician/M	in the past 12 menths? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 4 ☐ Pregnant at		h 3 □Ectopic pregnand 5 □ Other (specify) _	у		Month	Day Year
Р. О.	by the	hys	9 ☐ Unknown	9□ Unknown						
S,	The law requires that the ste has been signed by th bage 2 should be deteche	by P	Part II. Other significant conditi	ons contributing to death bu	ut not resulting	in the underlying cause gr	ven in Part I.	23e. Did toba	cco use contribute to	./
Ë	w require been sig should b						<del></del>	1 ☐ Yes	2 No 3 Pr	obably 4 🗗 Unknown
Record	aw requ 1s been 2 should	Completed						24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
	The law	E						performe	d2/ death?	2 □ No
Vitai	nyalclan: Th	Be	25. Was case referred to medica examiner?				26. Place of Death	(Check only one)		
o V	S 00 T	P	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie		utpatient 3 DOA			ce 6 □Other (Spec	cify)
	te e	ë ë	27. Manner of Death 1 DNatural 5 ☐ Pendi		y Year) 28b.	Time of Injury Wo		8d. Describe how	injury occurred	
sio	Attending r death. sctor; Atter by the fune	cat	2 Accident invest 3 Suicide 6 Could	not be			]Yes 2□No	Of Location (Stre	et and Number or Ru	iral Route Number
Division	or At after of Dirac in by	Certification;	4 Homicide determ	building, etc		farm, street, factory, office		City or Town,		, ar riodio ridinosi,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely illied in by the fu	a C		ng Physician: To the best of						
	n 24 h	edical	(Check only 2 Medical one)	Examiner: On the basis of and manner sta		.nd/or investigation, in my	opinion, death occurre	d at the time, date	e and place, and due	to the cause(s)
	vithly To the	ž	29b. Signature and title of certific			29c. Licen	se number	290	d. Date signed (Monti	h, Day, Year)
	/		11) the	Much.	201 400	1)0	034103	WA	e UL, o	4006
	6	1	30. Name and address of person	who completed cause of de	eath (Item 23a		000	I U	1 1 0	II. MO
	7	-	William J.	Frohna	MC	Onion 1	Memoria	1 11026	ITAI BY	inmore, 11
1	Sta Regist	ate	31. Date filed (Month, Day, Year JUN 0 6	2006 32. Jegistra	ar's Signature	1.1.				

			State of Maryland / Department of Health and M  State Certificate of Death		giene 2006	17662
	Physici	an	1. Decedent's Name (First, Middle, Last)  Jevry Anagnostou	2. Date of De	Day Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	June	Ac. County of Death	1
	Europel		Franklin Square Huspital Rosedale  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.	8. Date of Birt	Balti	
	Funeral Director		166-34-9273	Oct. 29	, 1936 Peni	nplace (State or Foreign untry) USYLVANÍA
	ehow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	the Mar 28e-1 e	ector	Maryland Baltimore Nottingham  10e, Street and Number 10f. Zip Code		10- Cition of What C	1 ☐ Yes 2 🛣 No
77	23a or	ai Dir	10e. Street and Number 9219 Gardenia Road 21236		10g. Citizen of What Co. U.S.A.	untry?
Jerr 036	hours after death with the Maryland turel', or Items 23a or 28e-f ehow al Examiner must be notitled at	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 X Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto If Yes, Give Year or Dates:	pecify Yes or No Rican, etc.)		
Anagnostou, Je Baltimore, Maryland 21215-0036	within 72 ene. then "nai	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  Restaurant Owner		16b. Kind of Business/I Self-Emplo Restaurant	yed
Sto	ag ta b	To Be (	George Anagnostou Mary	Stavl		
∩oS Maryla	ges 1 and 2 should to 6 Health and Men If Item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type, Print)  George Anagnostou (son)  19b. Mailing Address (Street and Number or Rur 9219 Gardenia Road, N			
nag timore,	pes 1 and 2 of Health of Item 27 is			Date	20c. Location - City or 1	
III N	Pa ant ury		4 Donation 5 Other (Specify) Annunciation Cemetery 6/5/		Baltimore,	
Ba Ba	permit. Depart Import any inj		Brien D. Jews 9705 Belair Road,		. Funeral Ho re, MD 2123	
8760,6	Physician /Medical Examiner physician and prize prize the prize transit	dical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	)		Interval Between Onset and Death
P.O. Box 6	requires that the death certificate een signed by the attending phys hould be detached for use as the	Physician/Me	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknown   23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 5   Other (specify)   9   Unknown   1   Unknown   Unknown   1   Unknown	23d. Date of delik Month	very Day Year	
	w requires that the de been signed by the s should be detached f	à	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use contribute to 'es 2 ☐ No 3 ☐ Pro	the cause of death?
al Reco	The law te has b	Completed		24a. Was a autop perfor 1 Yes	sy prior to co	opsy findings available ompletion of cause of
Vit.	Physicien: Th r this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1   Yes   2   No   Hospital: 1   Inpatient   2   ER/Outpatient   3   DOA   Cther: 4   Nursing Ho		ne) lence 6 ⊡Other (Speci	4.1
Division of Vital Records,	5 5 5 S	atlon: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  1 Yes 2 No		ow injury occurred	<u> </u>
Divis	To the Hospital or Attendit within 24 hours after death. To the Funerel Director: All completely filled in by the fu	Certification:	building, etc. (Specify)	City or Tow		
	e Hosp 24 hou e Fune letely fil	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the d red at the time, o	cause(s) and manner as state and place, and due t	stated. o the cause(s)
	To th withir To th comp	M	29b. Signature and title of certifier  29c. License number		29d. Date signed (Month,	
			William and address of person who completed cause of death (Item 23a) (Type, Print)		June 2,	
,	0		Diz William Andrew Renie 9000 Franklin Square Drive Bailim	ure M	eryland ?	1237
	Sta Registr		31. Date filed (Month, Day, Year)  JUN 0 6 2006  2. Registrar's Signature			

			1 - For Stete Registrar	State of Maryland / Dep Ce	partment of Health and I Pertificate of Death	Mental Hygiei Reg.	2000	17663
	Physici /Medi		1. Decedent's Name (First, Middle, Last)	B. Bristow	)	2. Date of Death Month	Day Year	3. Time of Death
	Examir		4a. Facility Name (If not institution, give s Bel Aic Health As	ed Rehab	4b. City, Town, or Location of Death 13 el Air		4c. County of Death	rd
	Funeral Director		5. Social Security Number 6. Sex 1 Usual Residence of Decedent	M 2017 7. Age (In yrs. last birthday 93 Yrs.	y If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 2 - // - /3	ar) \ Coun	lace (State or Foreign try) Sy /van; a
	hours after death with the Maryland turel; or Items 23a or 28a-f ehow al Examinar must be notified at	ctor	10a. State 10b. County Harfor	10c. City, Town or L	ocation Hoerdeen		1	0d. fnside City Limits 1 ☐ Yes 2
	sath with the 23s or 28	rai Director	10e. Street and Number 491 Wind mere	DR.	10f. Zip Code 2 1001		Citizen of What Coun	
036	ours after deal	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2  No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (S. If Yes, specify Cuban, Mexican, Puert	респу Y es or No- o Rican, etc.)	14. Race - Americ Black, White, of Specify:	
21215-0036	within 72 ene. than "na!	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) (Give	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	king 16b	. Kind of Business/Ind	ustry
Maryland 2	be filed Ital Hyg Id othe event,	To Be Co	17. Father's Name (First, Middle, Last)	Duchanan	8. Mother's Nan	ne (First, Middle, Maid	(In Sumame)	
-	ges 1 and 2 should it of Health and Mer if Item 27 is marke or other traumatic		19a, Informant's Name/Relationship (Type)	ristac JR. 491	ing Address (Street and Number or Ru	Aberdeo	nMD2	100/
Baltimore	permit. Pages 1 Depertment of H Important: if its eny injury or ot		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Ri 4 □ Donation 5 □ Other (Specify)  21. Signatyre of Funeral Service ⊬cense	Greenna	iosition (Name or armatory or other place)  Out Cromatay 6  22. Name and Address of Facility	7/06 B	Location - City or To	ND.
Ba	Deper Impo		23a. Portl. Enter the disease, or comple	XWI AU Fi	VANSFUNERALCHI	HEL:BELI	L, MO 2 AIR BNOW	
	Physician /Medical		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	yocardial	Infa	retion	Ons and Death
	Examiner	iner	Equentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.	Due to (or as a consequence of):	<u> </u>			
,8760,	icate be executed physicien and s the burial-transit	dical Examin	that initiated events resulting in death) Last	Due to (or as a consequence of):				
Box 6	death certii e ettending id for use a	Physician/Medi	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other ( <i>specify</i> )		23d. Date of deliver	ry Day Year
	sign d be	ρ	Part II. Other significant conditions con	ributing to death but not resulting in the ${\mathcal L}$	underlying cause given in Part I.		o use contribute to the	e cause of death?
		Completed	,			24a. Was an autopsy performed	prior to com death?	sy findings available apletion of cause of
Vita	Physicien: Th this certificete ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	ospital: 1  Inpatient 2  ER/Outpatie	04	th [Check only one]	6 Dothor (Specific	1
ion of	fune fune		27. Man of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time ( Injury		28d. Describe how in		
Divis	in Diffic	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)		City or Town, Sta		
	To the Hospital within 24 hours a Yo the Funeral I completely filled	Medical	29a. Certifier 1 Cartifying Phys (Check only one) 2 Medical Examin	cian: To the best of my knowledge, dea er: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur 29c, License number	red at the time, date a	and place, and due to	the cause(s)
	Son Son		▶ Man	me In	DI95	3 Ju	Date signed (Month, D	400 G
1	b `		Manuel M.	pleted cause of death (Item 23a) (Type	Print) & Lau	Sivee	the see	-deen,
	Sta Registr		31. Date filed (Month, Day, Year)  JUN 0 6 200	32. Sagistrar's Signature	neste		/ 10.1.1	7001

FLizabeth Bristow

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrer Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 12:58HM argare Dred 2006 JUNE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If no institution, give street and number Examiner tord Har HU 110 . Age (In yrs. If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex last birth day) Funeral Months 1 M 2 F Director 1-27-190 Germani Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f ahow The Medical Exaciner result be notified at 1 ☐ Yes 2 ☐ No ML Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21015 or Itams 23s 500 by Funera 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Hoo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. am 27 Is markad othar than "natural", or Itan 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ₩idowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) nom 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be earn zabeth HOL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type permit. Pages 1 and 2...
Department of Health ar Important: If itam 27 Is any injury or other trau Date 3 A M M 20c. Location - City or lown, State MD 21014 20b. Place of Disposition (Name of 20a. Methoet of Disposition cemetery, crematory or other place, 1 Deurial 2 Cremation 3 ☐Removal from State TOLL FOREST HILL 4 ☐ Donation 5 ☐ Other (Specify) kixed Comptery 106 10 21. Signature of Funeral Service Liq 22. Name and Address of acility MD21057 Approximate Interval Between Opset and Death 23a. Part 1. Enter the disease or complication shock, or heart failure. List only one cau that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest line. Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or s consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical as the b IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 10 in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the a 9 Unknown signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \text{Yes} \) \( 2 \text{\$\text{No}} \) No 24a. Was an autops 2 No 1 Yes Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) ASSISTED examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) ဂ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After or Attanding Injury 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral I Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 06-06-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) U BUSINESS ENTER WA

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0 6 2006

32. Sgistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician 6:10 2006 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | 1997 | Examiner HARFORD BRADENBAUGH 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☑ M 2 ☐ F Yrs. 220-52-4066 MARYLAND Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or iteme 23a or 28a-f show other treumatic event, the Madical Examinar must be nutified at 1 Yes 2 - No mD **Funeral Director** HARFORD HITE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 2 110 Specify: à 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) EmployEED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 KUSE ISHER 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 🤘 19a Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2:
Department of Health at
Importent: If item 27 is
eny injury or other treu-KD. WHITE HACK, MD DENBAUGH 026 20a. Method of Disposition 20b. Place of Disposition (Name of Date Cemetery, crematory or other place)

This HULL ALLOENS

Date

SunE 6

ACCE 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State TALKSTON MID 4 ☐ Donation 5 ☐ Other (Specify) 3 NEWPICT DR. FOREST HILL 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHAPEL - BEL AR MO 21050 FUNERAL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final Priysician ONE YEAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner FIVE YEAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a nonsequarios of) Examine ng physicien and see the burial-transit Due to (or as a consequence of) Box 68760, the ettending physicien Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy ō in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) detached ☐Yes 2☐No P.0. 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 2 No 1 Tes 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? eret Director; After this certificate filled in by the funeral director, pag Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours efter ö To the Hospital within 24 hours elected To the Funerel D 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number alla STEVEN F. JOLGA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1830 EAST Manmints 32. Begistrar's Signature 31. Date filed (Month, Day, Year) State JUN 0 6 2006 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1 tem / per fh 9857 /-12-06 vt State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year BROWN 21 Q M 1AGG/E 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore Hospital mar If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) MAV 25/9 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Days Months Hours 1 □ M 2 5 F 102 -Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No MARVILAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4300 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 Z No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK Specify: 3.X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) COOK VARIOUS KESTAURANTS UNKNOW! 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) TAMES ANNIE MURPHU 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) YORTER (DAUGHTER) 4300 WENTWORTH RD. ARDELCIE BALTIHORE, MD. 21207 Date / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS MEM. PARK 06-09-06 ARBUTUS. 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

22. Name and Address of Facility

23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate BROWN JR. FUNERAL HOME Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): days Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 🖭 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ANatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Examiner The law requires that the death certificate be executed burial-transit cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medicai Division of Vital Records, P.O. ģ Be Completed certificate has tor: After this certific the funeral director, Certification: To death. after death filled in by 6 within 24 hours a To the Funeral D completely lhe.

**Physician** 

/Medical

Examiner

Funeral Director

þ

Completed

Be

**Funeral** 

Director

the Manyland

Maggic

as

atient Baltimore,

Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified an once.

**Physician** 

/Medical Examiner

> State Registrar

31. Date filed (Month, Day, Year) JUN 0 6 2006

Caron

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , DO Sinai 32. Registrar's Signature

DO

~WY

Wany

Hospital of Spelle

29c. License number

R&S-000

29d. Date signed (Month, Day, Year)

Raltimore

ne 3,2006

**ORIGINAL** 

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [ 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Physician 4:15 PM KODIA Blevins May 30 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner pital N/A Har ber Da Itimore 8. Date of Birth (Month, Day, Year)
June 7, 19 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 217 68 3486 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours 1 ☐ M 2 🔼 F 50 Yrs Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits - Now in then "natural", or liems 23a or 28e-f ehover the Medical Evandor or must be notified at 1 ☐ Yes 2X No Maryland Director Anne Arundel Glen Burnie 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S. 21061 234 Poplar Avenue death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2XNo fYes, Give fear or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 7th permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Itam 27 ie marked other any njury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Briggs Betty Shipley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type Print) Paul Blevins II / Son 488 North Paturent Road Lot 5 Odenton, MD. 21113 1 Burial 2 TCremation 3 Removal from State
4 Donatol 5 Other (Société 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Bayview Crematory 6/2/2006 Baltimore, Maryland peral Service Lienuses 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signa 4001 Ritchie Highway Baltimore, Maryland 21225 n1. Ent if the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Link only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ventricular 8 minutes /Medical Examiner 40 Chraia Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of The law requires that the death certificate be executed Due to (or as a consequence of) use as the burial-Division of Vital Records, P.O. Box 68760, physician Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the causa of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? this certificate has ral director, page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2<del>21</del>No or Attending Physicien: Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 ☐ Yes 2 🔀 0 funeral dir 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Naturat 5 Pending 1 ☐ Yes 2 ☐ No death investigation 2 ☐ Accident in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled To the Hospitel 24 hours 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the

State Registrar

29b. Signature and title of certifier

eted cause of death (Item 23a) (Type, Print) .

29c. License number

00052022

Hospital -

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene

7663

Christopher J. Bigdeli 1- For State Certificate of Death Reg No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Medical Examiner 1812 hrs Christopher J. Bigdeli May 29, 2006 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1600 Ashby Square Apartment K Edgewood Harford 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9 Birthplace (State or **Funeral** oreign Country) Months Days Hours Director June 25, 1986 19 212-13-8459 1X M 2 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages I and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene and I Health and Mental Hygiene art. If freue 27 is marked other than "natural", or items 23a or 28a-f show or other trannatic event, the Medical Examiner must be notified at some. Harford Edgewood 1 Yes 2 X No Md. Director 10e. Street and Number 10f Zip Code 10g, Citizen of What Country 1600 K Ashby Square 21040 U.S.A. Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? White, etc. 1 X Never Married 2 Married 1 X Yes white 2 X No specify Divorced Widowed If Yes, Give Year Specify à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ MD 21215-0036 aircrew rescue swimmer 12 years rescue 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Cathleen Roloff Al Bigdeli Be 19b. Mailing Address (Street and Number or Rural Route Number. City or Town. State. Zip Code 6814 Cambridge Park Drive, Apollo Beach, F 19a. Informant's Name/Relationship (Type, Print ) Al Bigdeli/father Baltimore, N
permit Pages I and
Department of Healtl
Important: If item
injury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State 6/5/2006 Donation 5 Other Specify: Bayview Crematory Baltimore, Md. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel 2101/ Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not ente **Physician** failure List only one cause on each line Between Onset and /Medical Diabetic Ketoacidosis Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical X UNPENDED AMENDED item#23a,27,perME,g856,6/12/06 TT attending physician for use as the burial -Division of Vital Records, P.O. Box 68760, IE EEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown After this certificate has been signed by the funeral director, page 2 should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 🗸 Yes No To the Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one Be Other<sub>4</sub> Inpatient 2 DOA ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other Scene 1 🗸 Yes 2 No 28b. Time of Injury 28a. Date of Injury (Month, Day, Year 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Pending Yes 2 No hours after death To the Funeral Director: completely filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifie 29c License number 29d Date signed (Month, Day, Year) O.C.M.E. May 30, 2006 30. Name and address of person who completed cruse 35 eath (Item 23a) Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

			1 - For State Registrar	State of Marylan		tment of F ificate of			ene2 0 0 6	17669
			1. Decedent's Name (First, Middle, La	st)				2. Date of Death	_	3. Time of Death
	Physic /Medi		James E.	Bonds				June	Day Year 200L	17:50 am
	Exami		4a. Facility Name (If not institution, giv	e street and number)	4	b. City, Town, o	or Location of Death	VILLE	4c. County of Deat	
			3211 Piedmont	Avenue		Ва	ultimore		N/A	ļ
Ī	Funeral		Social Security Number     6. S	ex 7. Age (In yrs. I	7/	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		hplace (State or Foreign untry)
	Director		229-16-8897	83	Yrs.			Nov. 29,	1922 N	laryland
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Loca	tion				10d. Inside City Limits
	Aarylan f ehow	ō	Maryland N	/A	,,					1∭ Yes 2 No
	28a-	rect	10e. Street and Number	/A		Baltir 101. Zip Code	more	100	. Citizen of What Co	untry?
	3 with	0	4800 Pleasantvieu	o Avenue			21206	""		•
	death with the Maryland ms 23s or 28s-f ehow	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.	.S. 13. Wa	is Decedent of I-	tispanic Origin? (Spi an, Mexican, Puerto	ecify Yes or No-	U. S.	
ď	or its		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 X Yes 2 □ No If Yes, Give	1			Rican, etc.)	Black, White	e, etc.
00 5	ours.	by	3 ₩idowed 4 □ Divorced	Year or Dates:	1	Yes 2X No	Specify:		Specify: W	hite
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25	dithin	Id I	Elementary/Secondary (0-12)	Coflege (1-4or 5+)						
	lied v	ပိ	10th Grade 17. Father's Name (First, Middle, Last)		<u> Men</u>	ichant M			rmed Serv	uces
्रा है	ntal h	Be						(First, Middle, Ma.		
CA 2	2 should be filed within and Mental Hygiene.	2	Omer W. Bonds  19a. Informant's Name/Relationship (	Tune Print)	10h Mailing	Address /Ctrast			Unknown	
James Mar	t and 2 should Health and Men tiem 27 le marke		Shawn R. Harby (A	,, ,						
و کے	1 and Health Hem 27		20a. Method of Disposition		lace of Dispositi emetery, cremat	on (Name of	ry 31., b		Maryland Location - City or 1	
Tames E.	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Ie any injury or other free pnce.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification 2)		emetery, cremat t Holy				·	
:	ertme ortan inlur		21. Signature of Funeral Service Licer					imunah E	ltimore, ineral Hom	marykana
a a	permit. Depentimport any in		Burgin G 1	1110000					inelac nom L. Marylan	
			23a. Part1. Enter the disease, or com	plications that caused the death						Approximate
	Physician		shock, or heart failure. List only fmmediate Cause (Final	one cause on each line.						Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequ	ience of):					
	Examiner									
10		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):					
11/2	e be executed rsician and e burial-transit	Examiner	unat initiated events	c.						
ď	e be exersician a		resulting in death) Last	Due to (or as a consequ	uence of);					
8760		Ilcal		. d.						
Box 68	eath certificat attending phy	Physician/Medi	IF FEMALE:					_	1	
B	attence attence lor us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. ff yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetaf	death 3 □Ed	topic pregnancy	,		23d. Date of deliv	very Day Year
Ċ	trithe de by the	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5∐O	ther (specify)				
Division of Vital Records. P.O.	Attending Physician: The law requires that the death certilical releasing.  setor: Alter this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	F.	Part If. Other significant conditions o	ontributing to death but not resu	Ilting in the unde	riving cause give	en in Part I	23e. Did tobac	co use contribute to	the cause of death?
7	uires tha signed I	Completed by	Mungeal	neoplas		old				bably 4 □Unknown
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a d	The law ate has page 2 s	Ę	New Serve	C				autopsy performed	prior to co	opsy findings available ompletion of cause of
2	iclan: Th certificate rector, pag	CO	25. Was case referred to medical					1 ☐ Yes 2 Ø		2 No
5	ysiclan: is certific director,	ToB	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ E	EB/Outpationt	aCI DOA Othe	er: 4 🗆 Nursing Her	Check only one.	of our	Boosted
0	ding Phys h. After this funeral di		27. Manner of Death		28b. Time of	28c. Injun		28d. Describe how i	-	100 J
Ö	uttendin death. ctor: Alt y the fun	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury		k? Yes 2∐No			money
<u></u>	r Atte er de recto by th	£ 1	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, street,	, factory, office	2	8f. Location (Stree City or Town, S	t and Number or Run	al Route Number,
	rs aft	Certification:		Sandarig, Sta. (Optiony)	,			Only of Town, 3	ale)	
	To the Hospital or Attendia within 24 hours attendeath. To the Funeral Director: A completely filled in by the fo	edical	29a. Certifier 1 Certifying Ph	ysician: To the best of my knowniner: On the basis of examination	wledge, death or	curred at the tim	ne, date and place, a	nd due to the cause	e(s) and manner as	stated.
	the hain 24 the F	led		and manner stated.				o at the time, date	and place, and due t	o the cause(s)
	To To	Σ	29b. Signature and title of certifier	3		29c. License		29d.	Date signed (Month,	Day, Year)
	1.		My Colo	W _		200	35le74	V	we UI, U	
	4		30. Name and address of person who of wandlest 8mm	completed cause of death (Item	23a) (Type, Prin	11) 178.100	votren	Parkera	4 Suite 2	or Buer
	Sta	10	31. Date filed (Month, Day, Year)	32. Registrar's Signatu			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		i - jud	HZ 37
	Regist		ILIN O C 2006		1 4.					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 0 0 6

			1 - State Registrar		Cer	tificate of	Death		Reg. No.		
	Dharini	<i>Q</i> .	1. Decedent's Name (First, Middle, Las	t)				2. Date of D Month	Day	Year	3. Time of Death
	Physici /Medic	_	Mary M. Busse 4a. Facility Name (If not institution, give	.y				MAY	31 7	000	8:20 PM
7	Examin	er	4a. Facility Name (If not institution, give	Street and number)	PITAL	4b. City, Town, o	r Location of Dea	th	4c. Count	y of Death	4
3	Euperal	84. F	5. Social Security Number 6. Se		(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs	S. 8. Date of B	rth	9. Birtho	lace (State or Foreign
	Funeral Director		216-12-0497	□M 2/CXF	83 Yrs.	Months Days	Hours Min	May 15	,1923	Mari	iland
	D		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	eation				1	0d. Inside City Limits
	Aaryla Fahov	ō	MD N/A		Baltimore	Setion				,	1 □ Yes 2 □ No
	28a-	Director	10e. Street and Number		buccomore	10f. Zip Code			10g. Citizen of	What Cour	
	death with the Maryland me 23s or 28s-f show must be notified at	ai Di	4744 Shamrock A	ve.		21206			U.S.A.	)	
	eme 2	Inera	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 13. V	Vas Decedent of h Yes, specify Cub	dispanic Origin? ( an, Mexican, Pue	Specify Yes or N rto Rican, etc.)		ce - Americ	
20	hours after tural', or Ita	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ N If Yes, Give X Year or Dates:	10	☐ Yes 2 No	Specify:		Specia	ty: Whia	to.
3	2 hour		15. Decedent's Ed	ucation	16a. Deced	ent's Usual Occup	pation		16b. Kind of 8		
9500-61212	within 72 hours after death with the Marylar jiene. r then "natural", or Iteme 23a or 28a-f show tre Medical Examiner must be notified.	Completed	(Specify only highest gra	de completed) College (1-4or 5	+)	kind of work done OO NOT use retire		orking			
	led wil		10 th 17. Father's Name (First, Middle, Last)			Homemake	T	ame (First, Middle		1 Home	2
Maryland	ntai H ed oti	Be								ne)	
2	should ind Men marke umatic	ပို	Robert Smith 19a. Informant's Name/Relationship (1)	ype, Print)	19b. Mailin	g Address (Street		Le Rinef. Bural Route Numi		, State, Zip	Code)
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o O	of Healt fitem 2 r other		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo-	sition (Name of natory or other pla	ce)	Date	20c. Location	•	
attimore,	Pages Iment of tant: If it		4 Donation 5 Other (Specify	)	Sacred Hea	•	1		Balti		
Bail	permit. Pages Department of Important: If it eny injury or o		21. Signature of Funeral Service Licen	0000	22	Name and Addre	ess of Facility So	chimunek	Funeral	. Home	e, Inc.
	8 %a		23a. Part 1. Enter the disease, or comp	olications that caused	the death. Do not ente	31 Brehm or the mode of dyn				2121	Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final			1=11	10111				Interval Between Onset and Death
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×	entifica ding pt	Medical	IF FEMALE:	22a If was autoama	of oroganous					- Lander	
BO	eath ce attend	cian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal death 3	Ectopic pregnanc Other (specify)	у			ate of delive onth	ery Day Year
o.	oy the ached	Physician	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown							
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Records,	w require been si should I	ted						1 🗆	Yes 2 ⊠No	3 🗌 Prob	ably 4 Unknown
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	ulcian: The law certificete has rector, page 2 s		OS Mas area referred to modical					1 ☐ Yes	2 No	1 🗆 Yes	2 No
Vital	elcia: s certi	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 Inpatie	nt 2 ER/Outpatien	3 DOA Ott	200	eath <i>Check only</i> Home 5 Res		her (Specif	v)
Division of	g Phy ier thi	<u> -</u>	27. Manper of Death	28a. Date of Inju (Month, Day		28c. Inju. Wo			how injury occur		7/
Sio	endin sath. or: Afr	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	1	,		Yes 2 □No				
<u>×</u>	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuding, etc	ury - At home, farm, stre c. (Specify)	eet, factory, office		28f. Location City or To	(Street and Num. own, State)	ber or Rura	l Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director.		29a. Certifier 1 Certifying Ph	vsician: To the best	of my knowledge, death	occurred at the ti	me, date and place	e, and due to the	cause(s) and m	anner as s	tated.
	ne Hos ne Fur detely	Medical	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	examination and/or inv	estigation, in my o	opinion, death occ	curred at the time	, date and place,	and due to	the cause(s)
	Vitali Vitali To th	2	29b. Signature and title of certifier	1112 1	v LA	29c. Licens	_	)	29d. Date signe		
)			DSALIM BAG		//				MAY	31	2006
	10		30. Name and address of person who SALIM RAGHL	completed cause of d	eath (Item 23a) (Type, I SAMAIL) T	AN HOSE	TAI	5601 L	OCH ILA	MEH	BLVD LIZ39
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature		1 1 1 1 pers	BALIT	10100 - 1	יין עי	21023
13	Regist		31. Date filed (Month, Day, Year)	06 Bullian	J. J. An	ede					
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ORIGINAL

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Matthew Lewis Boening 1- For State Certificate of Death Reg No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ 0053 hrs **Medical Examiner** June 3, 2006 Matthew Boening Lewis 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Anne Arundel **Baltimore Washington Medical Center** Glen Burnie If Under 1 Year If Under 24Hrs. B. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Months Days Hours Director Country) 1 X M 2 39 Jan. 13,1967 216-92-6135 Usual Residence of Decedent 10d Inside City Limits my 10a State 10b. County 10c. City, Town or Location 1 Yes 2 X No or 28a-f show once. MD Glen Burnie Anne Arudel hours after death with the Maryland rector 10e. Street and Number 10g Citizen of What Country or items 23a or 28a-must be notified at 203 Nina Court 21060 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? White, etc. 1 Never Married 2 Married Yes 4 X Divorced 1 Yes 2 X No specify. White Yes, Give Year Specify Widowed Pages I and 2 should be filed within 72 hours after nent of Health and Mental Hyggene. ant: If item 27 is marked other than "natural", prother traumatic event, the Medical Examiner. \$ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Electrician Sign Company 1B.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Marvin Boening Frances Zoeller 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Frances Boening/ Mother 203 Nina Court Glen Burnie, Maryland 21060 20a Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State crematory or other place) June 9, Burial 2 X Cremation 3 Removal from State Chesapeake Cremation Department o 2006 Stevensville, MD Other Specify Dopation 22. Name and Address of Facility of Farcial Service Licensee Singleton Funeral Home, P.A. 101411 Second Avenue SW Glen Burnie, Maryland 21060 Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a Narcotic intoxication immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical AMENDED item#23a,27,28a-f,perME,g856,6/26/06 TT X UNPENDED signed by the attending physician i be detached for use as the burial Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b Was decedent pregnant in the 3 Ectopic pregnancy Live birth Month Dav Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 V Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? death? page Yes 2 No 1 V Yes certificate 26. Flace of Death (Check only one) 25. Was case referred to medical Be Other<sub>4</sub> examiner? Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 Nursing Home 5 Residence 6 this 2 1 V Yes No 28a Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 28b. Time of Injury Certification: Natural 1 Yes 2x No 5 Pending 6/3/2006 l2:07 am ımk 2 Accident Investigation 2Bf. Location (Street and Number or Rural Route Number, City or Town, State) 7840 Outling Avenue asadena, MD 2Be Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be 3 Suicide asadena, determined house (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29c License number 29d Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. June 3, 2006 30 Name and address of person who completed cause of death (Item 23a) Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Jack Titus MD: 31. Date filed (Month, Day, Year, 2. Registrar's Signature

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

JUN 0 6

2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Elaine Helen Burke 4:45 A June 1, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 3427 Kemptown Church Road Monrovia Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Yrs. 82 Director 217-18-0210 Mar. 9, 1924 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar must be notified at MD Frederick Monrovia 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3427 Kemptown Church Road Items 23s 21770 United States Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. illed within 72 hours after de Hygiene.
Hygiene.
other then "naturel", or Item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Christian Jacob Hauenstein Ethel Posey Bond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Sharyn Foster - Daughter 3427 Kemptown Church Rd., Monrovia, MD 21770 20a. Method of Disposition

→ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Mead OWP Capacity or other place) 20c. Location - City or Town, State Peges 1 Department of Important: If it ō 4 Donation 5 Other (Specify) Memorial Park 6-3-2006 Elkridge, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. Funeral Sarvices 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CIRRHOSIS YEARS /Medical Examiner YTHEMIA 7.54605 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Oue to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) o detached ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ğ cete hes been sig page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed3 certificete 1 Yes 2 No Division of Vital director Be 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 🗌 Suicide 28e. Place ol Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours e To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2006 00 59550 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WESTMUSTER MD MA GOURS HALL 31. Date filed (Month, Day, Year) 32. pgistrar's Signature State JUN 0 6 2006 Registrar

DHMH 17 Rev 1/2001

06-03720 Loren Andre Blake

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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21 lould d Mei s mai	ို	19a Informant's Name/F	Relationship	(Type, Print)		191	. Mailing	Address (St	reet and N	umber or R	ural Route Nu	mber, City	or Town	, State, 2	Žip Code)	
Baltimore, MD 2121 permit. Pages I and 2 should be fil Department of Health and Mental I Important: If item 27 is marked injury or other traumatic event,		DEBORAH		N/sist				W. B.		OURT	BAL	10 <b>,</b> MI				- 1
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06-03817 Wallace Boyd

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Physicia	n/	1. Decedent's Name (First, Middle,Last)	2. Date of Dea		3. Time of Death
ledical Examir		WALLACE BOYD	June 4, 2	006	1232 hrs
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and 2 lealth traun	1	SYLVIA BUTLER / SISTER 2725 MURA STREET  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	BALTO, Date	MD 21213 20c. Location - City o	
Baltimore, MD 21 permit Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatite et		Burial 2 Cremation 3 Removal from State GREEN MOUNT CREMATOR	3006	DAT DITMOD	E MD
altin mit. P partme	1	21. Name and Address of Facility		BALTIMOR	
E Per Co		Calvin B. SCRUG	GGS FUN 1 ST B	ERAL HOME	21213
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Box 687 death certifuthe attending of for use as t	sician	past 12 months?  4 Pregnant at time of death 5 Other (Specify)			20,
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Jivisi al or Att s after d I Direct	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location or Town,	(Street and Number or R State)	tural Route Number, City
Di lospital I hours a uneral I ky filled		29a. Certifier 4 Continue Physician To the heat of my knowledge, death accurred at the time date and place a	and due to the cau	uno(s) and manner as ets	artad
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.			
T. wi-	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (M	onth, Day, Year)
		O.C.M.E.		June 5, 2006	
Λ.		30. Name and address of person who completed cause of death (Item 23a)	04004		
Y		Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD  31. Date filed (Month 10 ) Year Consults and Street Signature.	21201		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 2006 2:07P Judith Bosley Ann /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Bel Air
If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Min 1 □ M 2 X F Months Days Hours Yrs. 218-54-4576 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a, State r then "natural", or items 23a or 28a-f ehov the Medical Exprehent has be notified at 1 ☐ Yes 2√2 No Director Maryland Harford Edgewood 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 72 hours after death with USA 1608 Candlewood Court 21040 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 X Never Married 2 ☐ Marned 1 ☐ Yes 2 X No 1 ☐ Yes 2X No Specity: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Heatth and Mental Hy Important: if Item 27 is marked other any injury or other traumatic avena 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Alice Virginia Singleton Thomas Edward Boslev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Price/Daughter 114 Darlington Road, Havre de Grace, Maryland 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Grove Presbyterian Cem. 06-05-06 Aberdeen, Maryland McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate 21. Signature of Funeral Service Licensee Immediate Cause (Final disease or condition resulting in death) PNEUMONIA **Physician** /Medical Due to (or as a consequence of) Examiner OBSTRUCTIVE PULLENARY DISEASE CHRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ned by the attending physician and detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Tilnknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RENAL PAILURE 1 Probably 4 □Unknown DISEASE HEMIET 24a. Was an autopsy performe 24b. Were autopsy findings available prior to comptetion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 ONo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐No 1 Plnpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 14 Coertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2.
To the I complet 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 008096 enNovaler s ms 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) "IST N, MAIN OF BELAIR, MD 2014 NowAKOWSKI MD 32 Registrar's Signature 31. Date filed (Mont

DHMH 17 Rev 1/2001

State Registrar Roland Frank Bollack

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

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		1. For State Registrar	ertificat	te of Deat	th		Re	g. No.	10 1/5/
Physicia dical Exami	an/	1. Decedent's Name (First, Middle,Last)  ROLAND FRANK BOLLACK					2. Date of Deat Month May 21, 20	h Day Year	3 Time of Death 2320 hrs
		4a. Facility Name (if not institution, give street and number)		4b. City,	Town, or Lo	ocation of Dea		4c. County of Dea	th
		519 Savage Street		Baltir				N/	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs	last birthd	lay) If Und Month	der 1 Year	If Under 24H Hours M	_	h(MM/DD/YYYY) 9. B Fore	inn
Director		212-60-3716 1XM 2F 53		Yrs.			SEPT.	14, 1952 c	ountry) MD.
any		Usual Residence of Decedent  10a. State 10b. County 10c. Ci	ty, Town or	Location					10d. Inside City Limits
ž	_	MD. N/A	BALT	ΓIMORE					1 XYes 2 No
faryka 28a-f	Director	10e. Street and Number		10f. Zip	p Code		10	g. Citizen of What Co.	untry?
Thours after death with the Maryland "natural", or items 23a or 28a-f show al Examiner must be notified at once.		519 SAVAGE STREET				21224	+	U.S.A.	
ith wit iems 2 it be n	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	U.S. 1			anic Origin? (: Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame White, etc.	rican Indian, 8lack,
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hours afte "natural", Examiner	à	or Dates:  15. Decedent's Education (Specify only highest grade completed)		ecedent's Usual			work done	Specify: WIT	
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215-( be filed natal Hyg rked oth	Be Co	17. Father's Name (First, Middle, Last)  ROLAND S. BOLLACK			18		ne (First, Middle, M E ESTELLE		
	To B	19a. Informant's Name/Relationship (Type, Print )	19b. I	Mailing Addres	s (Street a			ber, City or Town, Stat	e Zip Code)
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Page nent o			tro C	Crem.		0.5	31-06	Baltimore	, MD
Baltimore permit Pages la Department of Pl Important: If it injury or other 1		21 Signature of Funeral Service Licensee		22. Name and	Address o	Facility CI	HARLES S.	ZEILER & MORE, MARYL	SON, INC.
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/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Atherosclerotic Cardio						,, <u>-</u>	8etween Onset and Death
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ansit		events resulting in death) Last Due to (or as a consequence d.	-						
Division of Vital Records, P.O. Box 68760, no the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death for the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	//Medical	UNPENDED AMENDED							
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of Vital Records, ing Physician: The law require After this certificate has been si uneral director, page 2 should b	Т.	27. Manner of Death 28a. Date of Injury		ne of Injury	28c. Injury			Residence 6  Othe	er Scene
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Division tal or Attendir rs after death al Director: A	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number of Town, State)							ural Route Number, City
Di Hospital 24 hours Funeral tely filled	Cerl	4 Homicide (Specify) or Town, State)							
To the Ho within 24 F To the Fa	Medical	Certifying Physician: To the best of my knowle (Check only one) 2 Medical Examiner: On the basis of examination							
To the Vidin To the Comple	Med	and manner stated  29b. Signature and title of certifier	-		c License			29d Date signed (Mo	
Ď. v		high in mis			O.C.M	.E.		May 22, 2006	, , , , , , ,
nt by		30. Name and address of person who completed cause of death (Ite	em 23a)						
2 101		Ling Li, MD Assistant Medical Examiner 11		Street, Balt	imore, M	D 21201			
S	tate	31. Date filed (Month, Day, Year) 32. Registrar's Sign.	ature.	bouter					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Year EDWIN HIRLAM CURRY MAI 2:05 PM 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTHWEST RANDALLSTOWN BALTIMORE HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Yrs Jun 12, 74 Director 215-28-4381 1931 Maryland Usual Residence of Decedent with the Maryland r 28e-f ehow 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No MD Baltimore Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? à the Medical Examiner must be 238 3478 Dolfield Ave. 21215 USA death 12. Was Decedent Ever in U.S. Armed Forces? t3. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: \*51-55 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working unk life. DO NOT use retired) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) nnk17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Heelth and Mental marked James Ellison Curry Carrie Burrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heelth ar Importent: If Item 27 ie any injury or other trau . 5401 Old Court Rd. Randallstown, MD 21133 Northwest Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ADonation 5 ☐ Other (Specify) Ronald S. Wade 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 21. Signatura com 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Driset and Death Immediate Cause (Final disease or condition resulting in death) CHOLANGIOCARCINOMA Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, any, learning to Limediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical ettending for use as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 RENAL FHILURE been sig 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 1 ☐ Yes 2 No 25. Was case referred to medical examiner? director. 26. Place of Death | Check only one Hospital: 1 ₱ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 2 No this 28a. Date of Injury (Month, Day Year) Medical Certification; 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation M after death Director: , 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled is 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54352 30 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) かにてにも てのうりに NORTHWEST HOSPITAL 5401 OLD COURT ROAD RANDALLSTOWN

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) JUN 0 6 2006

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** MAILLIAM CHURCHWELL /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner HIOLY CROSS SILVER SPRING If Under 1 Year If Under 24 Hrs. 8. Date HOLTEOMERY MOSPIFAL 6. Sex 1 M 2 ☐ F 8. Date of Birth (Month, Day, Year) 05/24/1 9. Birthplace (State or Foreign Country)

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COUNT 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 28-56-300 10 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Itame 23a or 28e-f ehow the Medical Examiner must be notified at 1 Nes 2 No Director MONTGOMERY KENSINGTON MD 10g. Citizen of What Country? 10e Street and Number 20895 AZL 4000 MCCOMAS AVE Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Hygiene. Elementary/Secondary (0-12) College (1-4or5+) DEFT OF EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOLY CROSS HOSPITAL 1500 PORKST GLEN RD SILVER SPRING MD 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donetion 5 BOther (Specify) in state, 21. Signature of Funeral Service Licensee
Ronald S. Wado 22. Name and Address of Facility Director State Anatomy Board Baltimore, MD 21201 655 W. Baltimore Street 23a. Part Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner FUNGEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine PNEUMONIA ettending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed to should be dete Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ INFECTION 1 Yes 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate hes birector, page 2 s autopsy 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Intury 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D56063 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person WANWALTITUACI

ONLY OF BOOK 37 Registrar's Signal re 1500 PORRST CLEN RD SILVER SPRING MD 20910 State (Delle Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () ()

		1 = For State Registrar	State of Ivial	Cei	rtificate of	Death		. No.	) 1/6/9
Physici	an	1. Decedent's Name (First, Middle, Las	•				2. Date of Death Month	Day Year	3. Time of Death
/Media	cal	Margaret Ches			l		June	4,2006	16 P M
Examin	ner	4a. Facility Name (If not institution, give Since Hospital		·MACE		r Location of Death	aitu-	4c. County of De	
Funeral	_	5. Social Security Number 6. Se	7. Age (	In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bi	nthplace (State or Foreign
Director			⊐м 2 <b>∑</b> Г	66 Yrs.	Months Days	Hours Min.	9-12-3	gar) C	Carolina Carolina
and		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town or Lo	cation				10d. Inside City Limits
Maryl f eho	Ď	MI	/a	Detroit					1 XYes 2 □ No
r 28a	irec	10e. Street and Number			10f. Zip Code		100	J. Citizen of What C	Country?
th witt	aiD	4021 East Neva	da			48234		USA	
r dea	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of H II Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Arr Black, Wh	ite. etc.
permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23a or 28a-f ehow amy injury or other treumatic event, the Modical Examinar must be notified at ODGe.	by Funeral Director	1 ☐ Never Married 2 ☐ Married  3 ☐ Nivorced	1 □ Yes 2 No If Yes, Give Year or Dates:		1□Yes 2∏ No	Specify:		Specify: A1	rican- merican
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fental fental rked c	To Be	William Rogers				Dorothy	Pearson	1	
and N is ma		19a. Informant's Name/Relationship (7				and Number or Rura			
end and m 27		Ella M. Staten/				d Rd., I	-		
t of H		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	nemoval nom State	20b. Place of Dispo cemetery, crei				c. Location - City o	
it. Pa rtmen rtant: njury		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		King Mem	ı. Park	6/10	0/06 Ra	andallst	own, Md Balto. Co
perm Depa Impo any i		Manage of Parlierar Service Electric	" // // //	107 92	.Name and Addres	rtv Rd.	Randa	listown.	Md 21133
		23 Part1. Enter the disease, or com- shock, or heart failure. List only	cations that cause th						Approximate
Physician		Immediate Cause (Final							Interval Between Onset and Death
/Medical		disease or condition resulting in death)	a. Intra-	cerebic consequence of):	u hem	orrha	ge		3 days
Examiner		Sequentially list conditions	b						
p ts	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	опъециенсе оп).					
xecute and Il-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a c	consequence of):					
tificate be executed to physicien and as the burial-transit	aiE		·						
tificati g phy as the	ledicai		0.						
	M/us	230. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2 [		Ectopic pregnancy			23d. Date of de	alivery
w requires that the death cer been signed by the attendin should be detached for use	Physician/N	in the past 12 months? 1 □ Yes 2.☑ No 9 □ Unknown	4☐Pregnant at tin		Other (specify)			Month	Day Year
hat th		Part II. Other significant conditions co	antribution to death but i	not regulting in the u	ndorheina anuco ane	on in Part I	220 Did tobo	an una contributo	to the cause of death?
signe d be d	d by	Hypertens		iot resulting in the d	nderlying cause give	en in ranti.			Probably 4 JUnknown
v requ been shoul	iete	11912							
sician: The law certificate hes t irector, page 2 s	Completed				<u> </u>		24a. Was an autopsy performe	d? prior to death?	utopsy lindings available completion of cause of
an: T tificat tor, pa	a	25. Was case referred to medical				26. Place of Death	1 Yes 2	No 1 □ Ye	s 2 No
nysici iis cer direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 ER/Outpatier	nt 3 DOA Oth	or		e 6 □Other (Spe	ecify)
ng Pł fter th neral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time of	28c. Injun Worl		28d. Describe how		,
tendii eeth. or: A the fu	catio	2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 □No			
or At ofter d Direct in by	Certification;	4 Homicide determined	28e. Place of Injury building, etc. (	- At home, larm, str Specify)	eet, lactory, office	1	281. Location (Stree City or Town,	et and Number or F State)	Rural Route Number,
ours e	Ce	29a Certifier 1 Certifying Ph	nician: To the best of r	ny knawladaa ataon	Concurred at the fire	o data and clans a	CM has to the const	idel and item is	e atest of
To the Hospitel or Attending Physician: The law requires that the death cer within 24 hours effer death.  To the Funerel Director: After this certificate hes been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	dicai	(Check only 2 Medical Examone)	iner: On the basis of ex and manner state	camination and/or in:	vestigation, in my or	pinion, death occurre	ed at the time, date	and place, and du	e to the cause(s)
Vit ii	₹ Fe	29b. Signature and title of certifier			29c. License			. Date signed (Mon	
Q V		1 tatte	opy.	MO	KES	-000	J	une 4,	2006
5		30. Name and address of person who o	completed cause of dear	th (Item 23a) (Type,	Print)		00	15:	2006 re
Sta	ato.	31. Date filed (Month, Day, Year)	Ohy Begistrar's	Signature	au Ho	Spital	of Ba	Hime	78
Sta Registi		JUN 0 6 20	200	. 15 A	and I				
MH 17 Rev 1/2	0004		5	-	- W. A.				_

DHMH 17 Rev 1/2001

Patient Known as Margaret Chestnut

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 🛭 🗍 🦰 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3:50p M 27 Pay 2006 ear MAV Physician Sylvia Α. Campbell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Examiner Essex 947 Middlesex Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 218-32-6840 1 M 2 X F 68 Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State 28a-f show other traumatic event, the Medical Examiner must be notified at Essex 1 ☐ Yes 2 No MD Baltimore Director 10f. Zip Code 21221 10g, Citizen of What Country? 10e. Street and Number ö 947 Middlesex Road USA 238 death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes No 14. Race - American Indian, Black, White, etc. Items permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or Item eny injury or other traumatic event, Ita Medical and once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) own home Coflege (1-4or 5+) Elementary/Secondary (0-12) Homemaker 12th 18. Mother's Name (First, Middle, Maiden Sumame)
Macy Anabelle McCoy 17. Father's Name (First, Middle, Last) Edgar Allen Odie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 947 Middlesex Road Baltimore MD Harold G. Campbell/husband Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition Fairview Baptist Galax VA 6/3/06 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending phys IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 TNo been signed by the a should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CoRONDRY AT SKY DUESSE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \text{Yes} \) 2 \( \text{No} \) No 24a Wasan certificate has b autopsy 1 Yes 2 No To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1√0 ဥ 28a. Date of Injury (Month, Day Year) After thi funeral of 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 -Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DS5306 boup, res 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 9106 Hicmalina H. ODE DEMIS 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 0 6 2006 Registrar

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Maranda Michelle Callender 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day June 2, 2006 0927 hrs Medical Examiner Machelle Callender Maranda 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Raltimore University Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign Days Months Hours Director Country) 1 M 2 X F MD. 212-23-5516 17 Nov 11,1988 Usual Residence of Decedent 10d Inside City Limits 10a State 10b. County 10c. City, Town or Location Yes 2 X No 28a-f show Anne Arundel Brooklyn MD hours after death with the Maryland Director 10f. Zip Code 10g Citizen of What Country? 10e Street and Number or items 23a or 28a-7 r must be notified at o 21225 209 3rd.Avenue U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Funera Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 X Never Married 2 Married 2 X No Yes Divorced If Yes, Give Year 1 Yes 2 X No specify Widowed Specify: White "natural", ģ r Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 l nent of Health and Mental Hygiene ant: If item 27 is marked other than "no or other traumatic event, the Medical E **Baltimore, MD 21215-0036** 12 Secretary Painting 18 Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Dean Callender Dawn Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Dawn Johnson / Mother 209 3rd. Avenue Brooklyn, Maryland 21225 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) June 7, 2006 1 X Burial 2 Commation 3 Removal from State permit Pages
Department or
Important: I Glen Haven Mem. Park Donati Glen Burnie, MD Other Specify: 22. Name and Address of Facility 21. Signa neral Service Licensee  $^{22.\, ext{Name and Address of Facility}}$  Singleton Funeral Home, 1 Second Avenue SW GLen Burnie, MD 21061P.A. 1401411 or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Complications of Gunshot Wound to the Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical item#23a,27,28a-f,perME,g857,7/19/06 TI X UNPENDED AMENDED physician the burial that the death certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Dav Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 V Unknown g Unknown been signed by t should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death? page 2 performed? ✓ Yes 2 1 🗸 Yes 26 Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: Be Other<sub>4</sub> examiner? Hospital: 1 🗸 Inpatient 2 DOA Nursing Home 5 Residence 6 this ER/Outpatient 3 Other 2 1 🗸 Yes No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Yes 2 No 5 Pending Director: Nov. 2, 2004 unk subject shot 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 230 W. Fdgevale Road Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide determined (Specify) other-scene To the Funeral 4 X Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number June 4, 2006 O.C.M.E a 30. Name and address of person who completed cause of seath (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D.

32 Registrar's Signature

ORIGINAL

State Registra

31 Date filed (Month, Day, Year)

DO MUL

2006

	ian	1. Decedent's Name (First, Middle,					2. Date of De Month	Day	Year	3. Time of Death
/Media	cal	Donald E.  4a. Facility Name (If not institution,			4h City Town	or Location of Death	5	4c. County	OG of Death	1:04 P
Examir	ner		General Hospi	ta1		rlin			rcest	ter
Funeral Director				(In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da May 29	th ay, Year) 1938	Cour	place (State or Foreintry) yland
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death with the Maryland ms 23a or 28a-f show	jo		orcester	Too. Only, Town or	Willards				'	1 🗆 Yes 2 <b>X</b>
or 28a	lrec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?
ath wil	ralD	36398 Old Ocean				1874		Unite		
permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Hygiene.  Department must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 X Marrie 3 Widowed 4 Divorced	12. Was Decedent Every Armed Forces?  1 Tyes Tyen No. 1 Tyes, Give Year or Dates:		3. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto I Specify:	ecify Yes or No Rican, etc.)		ce - Americ ck, White, y: Wh	
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e filed of her vent, 1	e C	17. Father's Name (First, Middle, L	ast)			18. Mother's Name	(First, Middle			
Menta Menta arked atic e	To E	Robert Clarke				Eliza	beth S	mith		
12 sh h and 7 is m traum		19a. Informant's Name/Relationshi				and Number or Rura				
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w requires that the death certifications is a detached for use as should be detached for use as	Certification: To Be Completed by	in the past 12 months?  1	Hospital:    Hospital:   Inpatien     28a. Date of Injury (Month, Day ation of be ned     Pregnant at ti     1	t not resulting in the late 2 EP/Outpa  Year) 28b. Time Injur  Try - At home, farm, (Specify)  f my knowledge, de examination and/output  ath (Item 23a) (Ty)	e underlying cause gradient 3 DOA Ot 28c. Injury Wo M 1 Street, factory, office eath occurred at the trinvestigation, in my 29c. Licen	26. Place of Deathner: 4 \( \triangle \triangl	24a. Was auto perfu   1   Yes   1   Yes   1   Check only me 5   Resided Describe	Yes 2 No  an psy psy pomed? 2 No  dence 6 Ott how injury occur  Street and Numb wn, State)  cause(s) and m date and place, 29d. Date signe	3 Prob Were auto prior to cor death? 1 Ves  mer (Specify rred  ber or Rura anner as st and due to	psy findings availmpletion of cause 2 No  No  No  Route Number, lated.

State of Maryland / Department of Health and Mental Hygiene 2 [] [] [ For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death  $01^{\mathsf{Day}}$ Month 06 2006 ear **Physician** Heivy Roxana Caroca-Salas 5:00p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Hospice Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 11-29-1960 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Chile 1□M 🎞 F Months N/A Yrs. Director Usuel Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-1 show r than "natural", or items 23a or 28a-f shov the Medical Examinar must be notified at 1 ☐ Yes 2 No Gaithersburg Montgomery Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20878 9916 Shelburn Terrace #401 death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2X Married White XXYes 2□No Specify: Chile Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) at Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Banking Clerk Pages 1 and 2 should be filed v itment of Health and Mental Hygis rtant: if Itam 27 is marked other t jury or other traumatic svent, in 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Irene Salas Marin Eduardo Caroca-Nunez 19a. Informant's Name/Relationship (Type, Print) Daughter Nicole Andrea Castro Caroca 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9916 Shelburn Terrace #401 Gaithersburg MD 20878 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☼ Cremation 3 ☐ Removal from State 06-05-2006 Beltsville, MD permit. Page Department of Important: If any injury or once. Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility & Cremation Service M0038Z Sapart Johnson 933 Gist Av Silver Spring MD 20910 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lung Cancer Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and s the burial-transit Hospital or Attanding Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical attending pl 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 🖾 No 4☐Pregnant at time of death 5 Other (specify) ed by the a o 9□ Unknown 9 Unknown م ete has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 2K No 1 Tyes 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 1 ☐ Yes 2 🔀 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural after death.
I Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire 1🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of 06-03-2006 MD35635 9 30. Name and address of person who co pleted cause of death (Item 23a) (Type, Print) Joseph Kaplan MD 6001 Muncaster Mill Rd. Rockville MD 20852 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUN 0 6 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		•	For State Registrar	State of I	Marylan		artment <i>tificate</i>			Mental Hy	giene (	2006	17684
			1. Decedent's Name (First, Middle	, Last)		-				2. Date of De Month	Day	Year	3. Time ol Death
	Physici /Medic		ELIZABETH	MARGARET	СНО	DLEWC	ZYNSK	Ι		JÜNE	3,200	6	6:50 p м
)	Examin		4a. Facility Name (If not institution	-					cation of Death	1		ounty of Death	
			GENESIS HERI					LTIM				ALTIM	
	Funeral Director		5. Social Security Number 213-01-6097	6. Sex 1 ☐ M 2 🔀 F	Age (In yrs. 90	last birthday) Yrs.	If Under 1 Months		Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di MAY 7	, 1916	9. Birti MAR	nplace (State or Foreign YLAND
	D >		Usual Residence of Decedent  10a, State 10b, County		10c Cib	y, Town or Lo	eation						10d. Inside City Limits
	anyla •hov	5		′ <b>7</b> 3									XXYes 2 □ No
	28a-f	ect	MD. N/	A		BALTI	10f. Zip C	ode			10a. Citize	n of What Co	untry?
	with a s	₫	611 S. EAST	AVENUE				212	24		-	S.A.	,
	ne 23	era	11. Marital Status	12. Was Decede		.S.   13.	Was Decede	nt ol Hispa	anic Origin? (S	pecify Yes or N		Race - Ame	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Iteme 23s or 28s-f show other traumatic event, the Madical Exacil at must be notified at	by Funeral Director	1 Never Married 2 X Marr 3 Widowed 4 Divorced	If Yes, Give	No No		fYes, specif 1 □ Yes 2		Mexican, Puerti Specify:	o Hican, etc.)	sı	Black, White Dec <i>ify:</i> WH	e, etc. ITE
9	2 hou	ted	15. Deceden	t's Education		16a. Dece	dent's Usual	Occupatio	n ng most of wor	tina	16b. Kind	of Business/I	ndustry
21215-0036	thin 7	Completed	Elementary/Secondary (0-12)	st grade completed) College (1-4	or 5+)	life.	DO NOT use	retired)	ng most or wor	Kirig		OMBOR	T.C.
	filed with Hygiene ther the	S	8	1		H	OUSEW		Mathada Non	(First Adiabate	1	OMEST	·1C
Maryland	ould be fit Mental H arked ott atic ever	o Be	17. Father's Name (First, Middle, HENRY DORN						IARY	ne <i>(First, Middle</i> HAMIL)		imame)	
7	should and Men is marke aumatic	ဥ	19a. Informant's Name/Relations			19b. Mailir	ng Address (			ral Route Numb		own, State, Z	lip Code)
<b>≥</b>	nd 2 strate		MARGARET HOEN		R	1350	3 HOL	LY I	ANE, O	CEAN C	ITY, M	ID. 2	1842
Ē,	of Health of Hem 27 is		20a. Method of Disposition			Place of Dispo	sition (Name	of er place)	t	Date	20c. Loca	tion - City or	Town, State
E C	Pages nent of int: # It ury or o		¹ <b>X</b> ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		are	CRED			JĖSUS	6/7/0	6 BAI	TIMOR	E,MD.
Baltimore,	permit. Pages 1 Department of H Important: if Itel eny Injury or ott		21. Signature of Funeral Service	Licensee		L L 7	Name and ILLY 00 S.	Address CON	Facility CILER IKLING	INC. F	UNERA T.BAL	L HOM	E D. 21224
			· 23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau	sed the deat								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ATI	RIAI	FIF	3R11	11.	TION				Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or	as a conseq	uence of):	<u> </u>		TION				
	LXammer	<u></u>	Sequentially list conditions, if any, leading to immediate	b. END	as a conseq	36E	DER	154	7/1				
1/	ted	nlne	cause. Enter Underlying Cause (Disease or injury	A	6.40/1	001100 01).							
· ·	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a conseq	uence of):							
8760,	cate be executed physicien and s the burial-transit	dical		.OSTE	FOAR	2TH	2/ 1/	15					
9		Med	IF FEMALE:										
Вох	es that the death certifi igned by the attending be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?		h 2 ☐ Feta	Ideath 3	Ectopic pre				230	d. Date of deli Month	very Dav Year
0.	the deay by the a	ysic	1 Yes 2 No	4☐Pregnar 9☐Unknow	nt at time ol d m	eath 5	Other (spe	cify)					
٥	that the od by detac	Ph/	Part II. Other significant condition	ons contributing to dea	th but not res	ulting in the u	nderlying car	use given i	n Part I.	23e. Did	tobacco use	contribute to	the cause of death?
Records,	requires that een signed b nould be dete	d b								10	Yes 2□	No 3 Pro	obably 4 Donknown
Ö	> 9 %	lete								24a. Was		24b. Were au	topsy findings available
Re	0 - 0	Completed								auto perf	ormed?	prior to death?	completion of cause of
Vital	ician: Th certificate rector, pag	Be C	25. Was case referred to medica	I _				2:	6. Place of Dea	th (Check only		10,103	210110
<b>/</b>	w =	To E	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inp	atient 2	ER/Outpatier	nt 3□ DOA	Other:	4 Nursing H	lome 5 Res	idence 6 [	Other (Spec	cify)
n of	ding Ph h. After thi funeral		27. Manner of Death 1 D Matural 5 ☐ Pendir	28a. Date of (Month,	Injury Day Year)	28b. Time o Injury		c. Injury at Work?		28d. Describe	how injury o	occurred	
sio	tending leath. tor: After the funer	catl	2 Accident investi	gation			М		2 □No	001	(0)		
Division	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Certification:	4 Homicide determ	nined   286. Flace of	f Injury - At ho , etc. <i>(Specif</i>	ome, larm, sti y)	eet, factory,	office			(Street and town, State)	Vu <i>mber</i> o <i>r R</i> u	ral Route Number,
	spital		29a. Certifier 10 Certifyir	ng Physician: To the b	est of my kno	wiedge, deat	h occurred a	the time,	date and place	, and due to the	cause(s) ar	nd manner as	stated.
	1 24 h	Medical	(Check only 2 Medical one)	Examiner: On the bas and manne	is of examina	ition and/or in	vestigation, i	n my opini	on, death occu	rred at the time	, date and pl	ace, and due	to the cause(s)
	To th within To th comp	M	29b. Signature and title of certifie	. /			29c.	License n	umber		29d. Date 5	signed (Month	n, Day, Year)
			L'avi nou	L'SWELL	W 1	4)		2	788		615	106	
	d		30. Name and address of person	who completed cause	of death (Iten	n 23a) (Type,	Print)		λ.	0 0	1 -	7	
	0		XWINDLY 12	INVES 1	L Ma listrar's Signa	NUX	1/6	4	) cent	alce 1	10	412	22
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	6 2006	gistial s Signa	Jr Ja	barke						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#10b-c,18 perFH,0856.6/6/06 TT
State of Maryland / Department of Health and Mental Hygiene () () () Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 30 PM **Physician** 06 Salvatore J. Canelli /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Bayview Medical Center Baltimore City
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 2 F 84 213 20 540 Yrs. MD Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County item 27 is marked other then "netural", or items 23a or 28e-f show other traumatic event, the Medical Engineral must be inclined at BALFIMOP 1 ☐ Yes No MO Directo Dundalk **Baltimore** 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code MAPIE 4, 5, A 21222 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Agned Forces? 14 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should ba filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 Is marked othar than "natural; or Iterany injury or other traumatic event, the Medical Exametation." Once. 1 Never Married 2 Married If Yes, Give WWII þ WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician Electrical 6 . Mother's Name (First, Middle, Maiden Sumame) Phillamena Celozzi 17. Father's Name (First, Middle, Last) John Canelli Phillameania Cellozzi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Canelli - Wife 219 Maple Avenue, Baltimore, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-8-2006 Baltimore, MD Stanislaus 22. Name and Address of Facility  $Bradley-Ashton\ Funeral\ Home$ 21. Signature of Funeral Service Licens PA, 2134 Willow Spring Road, 21222 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death AMERIOSCEROTICARDIOVASULAR Immediate Cause (Final disease or condition resulting in death) 30YN Priysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient ► ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No 3□ DOA 27. Manner of Death Injury at Work? To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 29a. Certifier Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Division of Vital Records,

31. Date filed (Month, Day, Year)

1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 2006 2, Edith Louise Copenhaver June 4:00 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Gilchrist Center @ GBMC Baltimore Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M Yrs 70 June 24,1935 Maryland 220-32-2579 Director Usuel Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or Items 23s or 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Maryland Harford Joppa Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21085 **USA** 3532 Clayton Road 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eleanor (U/K) Niner David John Pape 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 119 Watson Way, North East, Maryland Pages 1 and 2 nent of Health a ant: If item 27 is Deborah Leftwich/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Holly Hill Mem.Gardens 06-07-06 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): alontas /Medical Examiner Sequentially list conditions, if any, leading to intrinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Physician/Medical as use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 DEctopic pregnancy signed by the atte Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 TUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has the irector, page 2 s autopsy performed 20 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Ather (Specify) Nospul 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funerel Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 05830 3 JUNE 2 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Browne up 21200 Clork AA2 da 660(N. 52 nonce 31. Date filed (Month, Day, 32. Signature State 2006 Registrar

Maryland 21215-0036

Baltimore,

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Records, P.

of Vital

Division

Edith

			For State Registrar	State of Maryland		tment of He ificate of E			giene20	16 17687
11/3	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Albert  D	avendost				2. Date of Dea Month	Day	3. Time of Death
	Examin	er 	4a. Facility Name (If not institution, give str HARBOR HOS 5. Social Security Number 6. Sex	AITAL 7. Age (In yrs. ias	t birthday)	4b. City, Town, or I	ocation of Deat	8. Date of Birt	4c. County of Balty	Death  MARE City  9. Birthplace (State or Foreign Country)
į.	Director		419-62-6414 1X/P  Usuel Residence of Decedent  10a. State 10b. County	M 2□F 58	Yrs.		11000	07-10-194	47 A1	Labama  10d. Inside City Limits
	with the Mar s or 28a-f st	Funeral Director	MD N  10e. Street and Number  4005 Sixth Street	IA .		Baltimore 10f. Zip Code 2122			10g. Citizen of Wh	1 X Yes 2 □ No nat Country?
036	be filed within 72 hours after death with the Maryland ital Hygiene. ud other than "natural", or items 23s or 28s-f show event, I're Medical Exercirer must be notified at	þ		2. Was Decedent Ever in U.S. Armed Forces? 1 ሺ Yes 2 □ No If Yes, Give Year or Dates:		as Decedent of His es, specify Cuban		Specify Yes or No- to Rican, etc.)		- American Indian, White, etc. Black
21215-0036	ed within 72 hagisene. er than "natu	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0·12) 12		(Give ki	nt's Usual Occupa nd of work done du NOT use retired) Custodian	uring most of wo		School S	System
yland	ould be file Mental Hy Marked oth	To Be (	17. Father's Name (First, Middle, Last) Forrest Davenport				I	Margaret Wa		
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23s or 28a-f show any injury or other traumatic event, to Medical Exarcinar must be multibut at ance.		19a. Informant's Name/Relationship (Type Vanessa M. Davenport / W. 20a. Method of Disposition  1	moval from State Carri	4005 se of Dispositietery, crema son For	Sixth Streetion (Name of Interpretation of Other Place est Vet. Contained Address	eet Baltin	nore, MD 21 Date  0-06	nr. City or Town, St 1225 20c. Location - C Owings Mil St. Balto,	ity or Town, State
8760,	Death certificate be executed size as the burial-transit and for use as the burial-transit	dical Examiner	23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one shock, or heart failure. List only one shock, or heart failure. List only one shock or heart failure. List only one shock of shock or shock of shock of shock or shock of shock of shock of shock of shock or shock of shock of shock or shock of shock o	Due to (or as a consequer	nce of):	the mode of dying				Approximate Interval Between Onset and Death
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ords, P	The law requires that the ate has been signed by the page 2 should be detache	ted by P	Part II. Dther significant conditions control  Hyper from 5100		ng in the und	erlying cause giver	n in Part I.	23e. Did to		ute to the cause of death?
al Rec		e Completed by	25. Was case referred to medical					1 Tes	sy prio med2 dea 2 No 1 □	ere autopsy findings available of to completion of cause of ath?  Yes 2 No
Division of Vital Records,	ing Phys After this uneral di	To B	examiner?  1 Yes 2 No Ho  27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation		NOutpatient  Bb. Time of Injury	3 DOA Other	4 Nursing H		lence 6 Other	
Divis	oitel or Attendurs after deathurs after deathurel Director; Ailled in by the filled in by t	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)				City or Tow	m, State)	or Rural Route Number,
	To the Hospitel of within 24 hours at To the Funerel D completely filled it	Medical	29a. Certifier (Check only one)  29b. Signature and title of certifier	cian: To the best of my knowle er: On the basis of examination and manner stated.	n and/or inve	stigation, in my opi	nion, death occi	irred at the time, o	date and place, and	mer as stated. d due to the cause(s)  Month, Day, Year)
•	4		30. Name and address of person who com	Inpleted cause of death (Item 2)	3a) (Type, Pi	int) Hosp	854	3001 R-11	June 3	2,2006 Hangver Street
100	Sta Registi		31. Date filed (Month, Day, Year) JUN 0 6 2006	Registrar's Signatur				- UM/1	7,0	

State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Month JUNE Day. **Physician** 2006 7:49 PM /Medical br Location of Death 4c. County of Death Baltimore 4a. Facility Name (Knot institution, give street and number) 4b. City, Town, **Examiner** ff Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** Days 4-1440 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 'natural', or iteme 23a or 28a-f ehow other treumatic event, the Madical Examiner must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code USH Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Yes 2 No
Yes, Give
Year or Dates: 1 Newer Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specity: White ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coflege, (1-4or 5+) 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or . / lelbourne 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (A cemetery, crematory of 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatifre of Funeral Service Licensee 22. Name nd Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between fmmediate Cause (Final disease or condition resulting in death) ACUTE CEREBROVASCULAR **Physician** /Medicat THROMBOSIS AND STROKE Examiner 1 DAY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-transit Due to (or as a consequence of): the attending physicien Box 68760 Physician/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal dea 4 Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav P.O. P 5 Other (specify) Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed: 1 ☐ Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other: ၉ 1 Yes 25 No 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation М 1 □ Yes 2 □ No within 24 hours after death. To the Funeral Director: A completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number D 12849 06-03-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 OSLER DRIVE, GHILADI, M. D. , TOWSON, MARYLAND 21204 31. Date filed (Month, Pay 32. Registrar's Signature State 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** DAWSON JOSEPH 0115PM JUNE 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CITY THE JOHN'S BALTIMORE HOPKINS HOSPITAL 7. Age (In yrs. last birthday)

57

Yrs. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 217-52-5708 M 2 F Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County show r then "natural", or items 23a or 28a-f shov the Medical Examinar must be notified at 1 ☐ Yes 2 No Kesville Himore Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 12. Was Decedent Ever in U Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Completed by 4X Divorced 3 ☐ Widowed Year or Dates: 61ac 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retized) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. 99 17 is marked other traumatic svent, 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Be ٥ oe Dawson re Health a n 20b. Place of Disposition (Name of Cemetery, crematory os other) Location - City or To Method of Disposition Depertment of H important: if ite any injury or of once. 1 Burial 2 Cremation 4 Other (Specify) Burial 2 Cremation 3 Removal from State 10-06 21. Signature of Furera Service Litense listown, ano 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DAYS HEART 121GHT /Medical Due to (or as a consequence of) Examiner SCHEMIA if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed after death. physicien and the burial-transit SEDSIS Due to (or s a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ has been signed by the part of 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? page this certificete 2 No 1 Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 npatient Other: 1 Yes 2 No Certification: To 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Injury death. 1 □Yes 2 □No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

JOHN

APOSTOLIDES

32. Togistrar's Signature

WD

and address of person who completed cause of death (Item 23a) (Type, Print)

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BALTIMORE

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2006

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrat Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vear **Physician** 31, 2006 Regina Elizabeth Domanski May 4:40 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 4610 Mannasota Avenue Baltimore N/A Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2 💆 F Months Days Yrs. 214-44-9462 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Directo Maryland N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ or items 23a 4610 Mannasota Avenue 21213 u. s. Α. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White. and Mental Hygiene. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Service Cordinator Hospital 12th Grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Robert Hittel 2 Dorothu Neal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any injury or other traum once. Dana Domanski (Husband) 4610 Mannasota Avenue, Baltimore, Maryland 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 06/06/2006 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licensee 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician netasta Phhereas cancer 06 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last nding physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To ihis 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Director: / d in by the fi 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 6/2/2006 D53070 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ba 1650 5+ Orleans 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 0 6 2006

ORIGINAL

DHMH 17 Rev 1/2001

Domanski, Regina

Vernon Joseph Daughton, Jr.

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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		Registrar Certi	moute o	Boatt	Reg_N	
Physicia al Exami		1. Decedent's Name (First, Middle,Last)  Vernon Joseph Daughton, Jr.			2. Date of Death Month Da May 29, 2006	17191115
		Facility Name (if not institution, give street and number)     Belfast Road Unit 12		4b City, Town, or Location of Death Timonium		4c. County of Death  Baltimore County
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday)	If Under 1 Year If Under 24Hrs	8. Date of Birth (N	IM/DD/YYYY) 9. Birthplace (State or
Director		215-68-3103   1 X <sub>M</sub> 2 F   51	Yrs	Months Days Hours Min	June 18	1955 Foreign Country) MD
	ŀ	Usual Residence of Decedent			parie 10	
v any		10a. State 10b. County 10c City, T	Town or Loca	tion		10d Inside City Lim
Aaryland 28a-f show 1 at once.	ē		ckeys		Lio	1 Yes 2 X
and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene tealth and Mental Hygiene tean 27 is marked other than "natural", or items 23a or 28a-f sho tranmatic event, the Medical Examiner must be notified at once traumatic event, the Medical Examiner	Director	10e. Street and Number		10f. Zip Code 21030	10g. (	Citizen of What Country?  USA
ith the 23a o notifi		13 Apt. I Windy Cliff Place  11. Marital Status 12. Was Decedent Ever in U.S.	13 W	as Decedent of Hispanic Origin? ( Sp	ecify Yes or No-	14. Race - American Indian, Black,
eath w	Funeral	1 Never Married 2 Married Armed Forces?		es, specify Cuban, Mexican, Puerto		White, etc.
fter de	by Fu	3 Widowed 4 X Divorced If Yes 2 X No	1	Yes 2 No specify:		Specify: Black
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ithin 72 h ne r <b>than "r</b> redical E	ompleted	Elementary/Secondary (0-12)  College (1-4 or 5+)				
led withi fygiene other tl	mo;	12 n/a  17. Father's Name (First, Middle, Last)	<u>SKII</u>	led Worker  18 Mother's Name	(First, Middle, Maid	Automotive en Surname)
uld be file Mental Hy marked o	Be C	Vernon Joseph Daughton, Sr.		Bernice	Johnson	
should be tiled with and Mental Hygiene 7 is marked other th natic event, the Med	2	19a. Informant's Name/Relationship (Type, Print )		g Address (Street and Number or F		
alth an		Ms. Joanne Daughton/sister	1	Cedar Lane, Co		11) 21044 Oc Location - City or Town, State
S ]		1 Removal from State Cremation 3 Removal from State	ematory or o	ther place) 6 /	5/06	•
Par nen ant		4 Donation 5 Other Specify.	_	nited Meth. Ch.		Cockeysville, MD
permit. Departn Import		21. Signature of Functor Service Aicensee	Ĺ	emmon Funeral H	ome of Du	ulaney Valley, Inc.
ysician	_	Michael . [Figure 23a Part Enter the disease in complications that caused the death I	Do not enter	10 W Padonia Ro the mode of dying, such as cardiac o	r respiratory arrest,	shock, or heart Approximate Inter
Nedical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Narcotic intoxica	ation			Between Onset a Death
aminer		or condition resulting in death)  Due to (or as a consequence of):				
	<u>.</u>	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):				
	miner	cause. Enter Underlying Cause (Disease or injury that initiated				
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rtificate be executed ing physician and as the burial - trans	an/Medical	IF FEMALE: 23c. If yes, outcome of pregna		7,0000,000		23d. Date of delivery
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x requir s been s should	Completed				24a Was an autopsy	24b Were autopsy findings availate prior to completion of cause of
The lavicate has	ᄩ				performed 1 <b>Y</b> Yes 2	d? death? No 1 ✓ Yes 2 No
an: T ertific ctor, p	Bec	25. Was case referred to medical		26.Place of Death (Check	only one)	
hysici this c	10 E	1 V Yes 2 No	ER/Outpatier			sidence 6 🗸 Other Scene
ling P After funera	E	(Month, Day, Year)	28b. Time of		28d Describe how	injury occurred
Attend death ector:	gţi.	2 Accident Investigation FIRG 5/29/2000	Fnd 5:1	eet, factory, office building, etc.	unk	et and Number or Rural Route Number, C
spital or Attending Physician; ours after death neral Director; After this certifi filled in by the funeral director,	Certification:	Suicide b A Could not be determined (Specify)	idence	set, factory, office building, etc.	Timonium.	5 Belfast Rd. Unit 12
To the Hospital or Attending Physician: The law requires that the death cer within 24 blours after death Tro the Funeral Director: After this certificate has been signed by the attendi completely filled in by the funeral director, page 2 should be detached for use		4 Homicide (Specify) 1 Certifying Physician: To the best of my knowledge		urred at the time, date and place, and		
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and manner stated	d/or investig	ation, in my opinion, death occurred	at the time, date and	place, and due to the cause(s)
F 3 F 3	Me	29b. Signature and title of certifier		29c. License number	1.	Od Date signed (Month, Day, Year)
	1	Theody Il. That -	4.0	O.C.M.E.	N	May 30, 2006
			23a)		-	
		30. Name and address of person who completed cause of deat (Item 2		- Charles Deltin	1201	
		Theodore King MD. Assistant Medical Examiner		enn Street, Baltimore, MD 2	1201	
S Regis	tate	Theodore King MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signatur		enn Street, Baltimore, MD 2	1201	

State of Maryland / Department of Health and Mental Hygiene ( 1 - For State Registrar Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 10:42pM Deitering UNE 2006 00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BAltinure
If Under 1 Year If Under 24 Hrs. Merry Medical Center 8. Date of Birth (Month, Day, Year) June 3, 1943 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 300-38-1359 6. Sex **Funeral** Min. 1**X**M 2□F Months Days Hours 62 Ohio Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show the Medical Examiner must be natified at 1 ☐ Yes 2 No Director Baltimore DUndalk MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 50 Vista Mobile Drive 23a Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or items 11. Marital Status 2 should be filted within 72 hours after and Mental Hygiene. 1 Never Married 2 Married Specify.White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Longshoreman Shipping 12 years permit. Pages 1 and 2 should be liled w Department of Health and Mental Hygien important: if Item 27 is marked other til any injury or other traumatic event, III QUEB. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Leo Joseph Deitering Sr. Rosa V. Murry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 50 Vista Mobile Drive, Dundalk, Maryland 21222 Shirley Deitering wife 20b. Place of Disposition (Name of cemetery, crematory or other place) June 6, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2006 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore City, MD. 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** UNA LANLEY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the attending physician and the dor use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 No 1 ☐ Yes 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours afler death.

To the Funeral Director: After this certifica completely filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death [Check only one] 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Cartifying Physician. To the best of my knowledge ideath conurred at the time idea and place, and due to the rauss(s) and malician estated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ·mD P18547 30. Naw and address of person who completed cause of death (Item 23a) (Type, Print) MATTHEW Nolan, mo 301 St. Paul Place Baltimore, mo 21202 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		- For State	•	Ce	ertifica	ate of	Death				Reg No	_ <		0 1/53
Physicia		Decedent's Name (First, Midd	lle,Last)				_		2.	Date of De Month	ath Day	Year		3. Time of Death
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		4a. Facility Name (if not institution	on, give street and no	umber)		41	Baltimore		f Death		4	c. County of	Death	
		University Hospital	6. Sex	7 Age (In yrs.	lost hirth	oday)	If Under 1 Ye		r 24Hrs	8 Date of F	Birth (MN	//DD/YYYY)	9. Birth	place (State or
Funeral Director	-	5. Social Security Number		7 Age (III yis.			Months Da						Foreign	1
Director	L	218-22-5164	1 X M 2 F		79	Yrs.	<u> </u>			Oct.	8,	1926		ntry) Maryland
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Maryland 28a-f show 1 at once.	흲	Maryland Harf	ora	_ AL	ELUC	<u> </u>	10f. Zip Code				10g. Ci	itizen of Wha	at Coun	try?
death with the Maryland or items 23a or 28a-f sho must be notified at once	Director	207 Darlingt	on Avenue				21001	L			US	SA		
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eath v	Funeral	1 Never Married 2 N	Armed F	orces?		If Ye	s, specify Cuba	an, Mexican,	Puerto Ri	can, etc.)		White,		
fler d	Ę/	3 Widowed 4 Di	vorced If Yes, Give Ye or Dates:				Yes 2X N					Specify:	Whi	
hours after "natural", Examiner	d by	15. Decedent's Education (Sp.	ecify only highest gra				's Usual Occup				16b.	. Kind of Bus	iness/In	dustry
6 172 h cal E	Completed	Elementary/Secondary (0-12	) College (	1-4 or 5+)	1	ailma	_				1	J.S. G	OT 7Q1	mment
Nedi	Ĕ	12			I <sup>V</sup> lc	шша		18 Mother	s Name (F	First Middle		n Surname)		THICH
IS-(		17. Father's Name (First, Middle Clarence Earl		77								hnson		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be	19a. Informant's Name/Relation		1	198	o. Mailing	Address (Str							Zip Code)
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once		Shirley Blevin		r			keview							
and 2	1	20a. Method of Disposition				of Disposi	tion (Name of o	emetery,		Date	200	. Location -	City or	Town, State
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'injury or other traumatic event, the Medical		1 Burial 2 Crematic		from State			morial	Grdn	6-6	-06	1 2	berde	en.	Maryland
Itin nit Pa artmen ortan	1	4 Donation 5 Other 3 21. Signalule of Funeral Service		110	11.101		ame and Addre							
Ba Perm Depu	1	Stally (H)	luck			1 1	317 Col	tesbur	V KO	ad, Al	oln c	gaon, .	Mary	land 21009
Physician		23a Part I Enter the disease, of failure. List only one cause	or complications that	caused the dea	th. Do no	ot enter th	e mode of dyin	g, such as c	ardiac or r	espiratory a	arrest, s	hock, or hea	irt	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease	Maritim In In	juri <b>e</b> s										Death
Examine		or condition resulting in death)	Due to (or as	a consequence	e of):									
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cial	eģ	UNPENDED									13	23d Date of	deliven	
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Boy e death the att	Physician/Medical			nown		- i- th	underlying on u	o anyon in Pr	ort I	23e Du	d tobacc	co use contri	ibute to	the cause of death?
that th	by P	Part II. Other significant cond	attions contributing	to death but no	ot resultir	ig in the u	inderlying caus	e given in Fe	aiti.	1				ably 4 Unknown
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cords, aw requir has been s	plet										topsy rformed		orior to d death?	completion of cause of
Rec The 1st cate h	Completed									1 🗸 Ye	s 2	No 1	<b>√</b> Ye	s 2 No
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F Vit Physic r this	ျ	1 Yes 2 No 27. Manner of Death		Inpatient 2 te of Injury		Time of I		njury at Worl				injury occurr		
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SiO Atten death ector: by the	cati	2 🗸 Accident In	vestigation 28e Pl	ace of Injury - A	t home 1	farm. stree	et, factory, offic	e building, e	tc.	28f. Locatio	n (Stree	et and Numb	er or Ru	ral Route Number, City
Divi al or s after al Dir	Certification:	de	build not be	y) Major R						or Town Route 22	n, State)	) berdeen T	hruwa	y, Aberdeen, Md.
spi		4 Homicide 29a Certifier 1 Certifying	Physician: To the b	est of my know	ledge, de	eath occur	rred at the time	date and pl	ace, and o	due to the c	ause(s)	and manner	as star	ted.
To the Ho within 24 P To the Fu completely	Medical	(Check only one) 7 Medical E	xaminer: On the bas	is of examination	n and/or	investiga	tion, in my opin	ion, death o	ccurred at	the time, da	ate and	place, and c	lue to th	e cause(s)
To To	ĕ.	29b. Signature and title of der		16			29c Lici	ense number			29	d Date sign	ed (Mo	nth, Day, Year)
		X/N/A	fy /	1			О.	C.M.E.			Jı	une 2, 20	06	
LX		Name and ross of pers	on who completed ca	ause of death (I										
9		Susan Hogan MD.	Assistant Med	lical Examir	ner 1	I11 Per	n Street, B	altimore,	MD 212	201				
	tate		,	<b>Pe</b> gistrar's Sig	nature	An	alls)							
Regis		JUN 0	6 2006	MASSAGE		Jan.	- Graz							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 0 03 P 2006 DDL Juno /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Johns Hopkins Boguieu Medical (4, 10). Baltumore (State of If Under 24 Hrs. 8. Date of Birth
Hours Min. (Mgnth, Day 29a)

October 12, 1953 7. Age (In yrs. last birthday) **Funeral** Months Days 15€M 2□F Delaware 52 216-56-2052 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County r then "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director Dundalk Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 USA 3125 Vulcan Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Transcare Ambulance Service EMT 12 years or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit, Pages 1 and 2 should be flik Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 2008. Minnie Joseph Howard Ennis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3125 Vulcan Road, Dundalk, Maryland 21222 Margaret Ennis Wife Baltimore. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition June 5, Gardens of Faith 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rossville, MD. 2006 21. Signature of Funeral Service Licenses Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Morniation erebra /Medical Due to (or as a consequence of): Examiner ainstern Sequentially list conditions, I any Lading I immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physicien and for use as the burial-transit certificate be executed 51 resulting in death) Last Due to (or as a consequence of) Box 68760, Physiclan/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death signed by the at d be detached for 5 Other (specify) o 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Dunknown been si Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificete has rector, page 2 2 No 0 ma 1 Yes 2 No 1 TYes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 212No Impatient 2 ER/Outpatient 3 DOA within 24 hours efter death.

To the Funerel Director: After this completely filled in by the funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital or A within 24 hours after 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD, Neurolosy Jr Resident 30. Name and address of person with completed cause of death (Item 23a) (Type, Print)
AA-1101heu 3029 Durylouk

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

**ORIGINAL** 

32. Registrar's Signature

Baltimore, MD 31322

			1_ For	State of Maryla	and / Depa	rtment o		•		116	17695
			Registrar		Cen	tiricate	of Death	2. Date of De	Reg. No.		3. Time of Death
	Physicia	an	Decedent's Name (First, Middle, Last)  Tomas and	т	Tr.Ar	wards		Month	Day	Year	12130 P M
	/Medic	al	James 4a. Facility Name (If not institution, give st	J.	EQV		wn, or Location of Death	6	4c. Cour	nty of Death	101
	Examin	er	M-	are Hose	121		OSECLATE			Him	CRE
	Funeral		5. Goodan Gooding Hambon	7. Age (In yi	rs. last birthday)	If Under 1 \	Year If Under 24 Hrs.	8. Date of Bir	th Vozel	9. Birth	place (State or Foreign
	Director		218–22–1157	M 2□ F	78 Yrs.	Months D	Days Hours Min.	8. Date of Bir (Month, Da October	14,1927	Mary	land
	pu .		Usual Residence of Decedent  10a. State 10b. County	100	City, Town or Loc	nation					10d. Inside City Limits
	lanyla shov	7	MD. Baltimore		Dunda						1 ☐ Yes 21 No
	the M	ect	10e. Street and Number		Darac	10f. Zip Co	ode		10g. Citizen o	of What Cou	ntry?
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Itsms 23a or 28a-f show int, the Medical Examinar mast be notified at	Completed by Funeral Director	7048 Belclare Road	E			21222		US	SA	
	death	nera	11. Marital Status	2. Was Decedent Ever in Armed Forces?	1 U.S. 13. W	Vas Deceden	of Hispanic Origin? (Sp Cuban, Mexican, Puerto	ecify Yes or No	)- 14. R	ace - Ameri lack, White,	
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	e filed ofher vent, tr	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle	, Maiden Sum	ame)	
A lar	uld be Menta Irked Itic ev	TO B	George M. Edwards				Elizab	eth Cur	ran		
a Reds,	s 1 and 2 should be filed within Heelth and Mental Hygiene. Item 27 is marked other there other traumatic event, the M	1 8	19a. Informant's Name/Relationship (Typ				Street and Number or Rui				
and a	s 1 and 2 of Heelth item 27 I		Victoria M. Edward		7U48 D. Place of Dispos		are Road, D		20c. Locatio		
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Ba	permit. Peges Department of I Important: If its any injury or o		Ehrthours.	Connos	lly?	Connel 7110 S	Address of Facility Ty Funeral Ollers Poin	Home Of t Road,	Dunda] Dunda]	k,P.A k,MD.	21222
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O.	the all	ysici	1 Yes 2 No	4 Pregnant at time of 9 Unknown	of death 5	Other (spec	ify)				,
P.O.	that the ed by detac	by Physician/Med	Part II. Other significant conditions con	tributing to death but not	resulting in the un	nderlying cau	se given in Part I.	23e. Did	tobacco use co	ontribute to t	the cause of death?
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<u> </u>	hysic his ce I direc	To	examiner? 1 ☐ Yes 2 💆 No		2 ☐ ER/Outpatien			ome 5 🗆 Res			fy)
٥	ing P		27. Manner of Death  1    Natural 5 □ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury		. Injury at Work?	28d. Describe	how injury occ	urred	
Sio	tend death tor: /	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - A	t home form etc	M .	1 Yes 2 No	28t Location (	Street and Nu	mher or Rue	al Route Number.
Division of Vital Records,	el or A s aftar al Direct	Certification:	4 Homicide determined	building, etc. (Spe		eet, factory, c	mice	City or To	wn, State)		ar riodio rambor.
7	To the Hospitel or Attending Physicien: The law requires that the death certificat within 24 hours attar death.  To this Funeral Director: After this certificate hes been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical (	29a. Certifier 12 Certifying Phys (Check only one)	ician: To the best of my ler: On the basis of exam and manner stated.	knowledge, death nination and/or inv	occurred at vestigation, in	the time, date and place, my opinion, death occur	and due to the red at the time,	cause(s) and date and plac	manner as s e, and due t	stated. o the cause(s)
	ro the	₩	29b. Signature and title of certifier			29c. L	icense number		29d. Date sig	ned (Month,	Day, Year)
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	81		30. Name and address of person who con	mpleted cause of death (	Item 23a) (Type,		•				
_	U		DR. Jacques	Conquai	90	000	Fran Klin	29 war	ede B	rHimo	RE, MD 2123"
	Sta Regist		31. Date filed (Month, Day, Year) JUN 0 6 2006	31 Registrar's Si	dnature	West of					

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		al Residence of			10a Cibi	Town or Location					ı	10d. Inside City Lim
		. State	10b. County Hari	Ford	Toc. City,	Town or Location	Abi	ngdon				1 □ Yes 2
Director	100	. Street and Num				10f	Zip Code			10g Citize	en of What Cou	
٥	100		en Court			1.01.	Lip Godo	21009		-	.S.A.	,
PFB	11.	Marital Status	en doute	12. Was Decedent	Ever in U.S	. 13. Was De	ecedent of H	lispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No-	14	4. Race - Amer	
Funeral		1 Never Marrie	ed 2 Married	Armed Forces?	No		specify Cuba s 2 🕱 No	Specify:	Hican, etc.)		Black, White	,etc. rhite
4 5		3 ☐ Widowed	4 □Divorced	If Yes, Give Year or Dates:		†				3	Specify: W	
Completed by		(Speci	15. Decedent's Edify only highest gra	ducation ide completed)		16a. Decedent's t (Give kind of	Jsual Occup work done	ation during most of worki d)	ng	16b. Kind	d of Business/I	ndustry
iga m		Elementary/Secor		College (1-4or	5+)	genera.				brew	erv	
2	17	Father's Name (	First, Middle, Last,			genera	I mana	18. Mother's Name	(First, Middle,			
BB		,	J. Fishe					Amelia	Matosk	a		
٢	-		me/Relationship (			19b. Mailing Add	ress (Street	and Number or Rura	I Route Numbe	r, City or	Town, State, Zi	p Code)
	1	Villiam	Fisher/s	on		2902 A	uden (	Court, Abi	ingdon,	MD 2	1009	
	20	a. Method of Disp			20b. Pla	ace of Disposition (	(Name of or other place	ce)   C	ate	20c. Loca	ation - City or T	own, State
			□Cremation 3 L 5 □ Other (Specifer)	]Removal from State y)		view Cre			2006	Ba1	timore,	Md.
			paral Service Licer		/	22. Name	e and Addre	ss of Facility Funeral F	lome of	Be1	Air, Ir	ıc.
ľ		M	14	plications that caused one cause on each li		610	W. Mac	Phail Roa	d, Bel	Air,	Md. 21	014
ner	di	mediate Cause ( sease or condition sulling in death)  quentially list core any, leading to im use. Enter Unde use (Disease or at initiated events		Due to (or as	a consequ	ence of):	CA.	KUNOW	4			Interval Between Onset and Death
adical Examiner	re	use (Disease or at initiated events sulting in death) L	ast	c. Due to (or as	a consequ	ence of):						
Physician/Mad	IF 23	FEMALE: b. Was decedent in the past 12 1 Yes 28 9 Unknown	months?	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3 ☐Ectop	ic pregnancy r (specify)	<b>y</b>		23	3d. Date of deliving Month	very Day Year
hy Di	Pa	rt II. Other signif	// /	contributing to death b	ut not resu	lting in the underlyi	ng cause giv	ren in Part I.	23e. Did to	bacco us	e contribute to	the cause of death?
7			MEUNG	14 14		-			1 □ Y	'es 2□	No 3□Pro	bably Unkno
Completed									24a. Was autop		24b. Were aut	opsy findings availa
E									perfor	med?	death? 1 ☐ Yes	202No
	2		red to medical					26. Place of Death		X		
9	25	. Was case refer		Hospital:	ent 2 🗆 E	ER/Outpatient 3	DOA Oth	ner: 452 Nursing Ho	me 5 Resid	lence 6	□Other (Spec	ify)
a	25	. Was case reference examiner?		1 Inpati			28c. Injur	y at	28d. Describe h	ow injury	occurred	
To Ba	25	examiner? 1 Yes 20	No h	1 ☐ Inpati 28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	28c. Injur Wor					
To Ba	25	examiner? 1 ☐ Yes 20	No	28a. Date of Inju (Month, Da	y Yea <i>r)</i> jury - At ho	Injury M me, farm, street, fa	10	Yes 2 □ No	28f. Location (S City or Tow	Street and In, State)	Number or Rui	al Route Number,
Cortification: To Bo	27	examiner? 1 Yes 2  Manner of Deati Natural Accident 3 Suicide	No  5 Pending investigation 6 Could not be determined	28a. Date of Inju (Month, Da	ury - At horder. (Specify, of my know of examination	Injury M me, farm, street, far )	ctory, office	Yes 2 □ No	City or Tow	n, State) cause(s) a	and manner as	stated.
To Be	27	examiner?  1 Yes 22  Manner of Deatt Natural Accident 3 Suicide 4 Homicide	No 5 Pending investigatio 6 Could not be determined	28a. Date of Inju (Month, Da  28e. Place of In building, el	ury - At horder. (Specify, of my know of examination	Injury M me, farm, street, far )	ctory, office	Yes 2 □ No	City or Tow and due to the c ed at the time, c	n, State) cause(s) a	and manner as	stated. to the cause(s)
Cortification: To Be	27	examiner? 1   Yes 22   Manner of Deatt 2   Accident 3   Suicide 4   Homicide  Da. Certifier (Check only one)	No 5 Pending investigatio 6 Could not be determined	28a. Date of Inju (Month, Da  28e. Place of In building, el	ury - At horder. (Specify, of my know of examination	Injury M me, farm, street, far )	tred at the turtion, in my c	Yes 2 □ No	City or Tow and due to the c ed at the time, c	n, State) cause(s) a	and manner as	stated. to the cause(s)
Cortification: To Be	27	examiner? 1   Yes 222   Manner of Deatt 2   Accident 3   Suicide 4   Homicide  Da. Certifier (Check only one)	S Pending investigation 6 Could not be determined title of certifier	28a. Date of Inju (Month, Da  28e. Place of In building, el	of my know of examination	Injury M me, farm, street, far wledge, death occur ion and/or investiga	tred at the turtion, in my c	Yes 2 □ No	City or Tow and due to the c ed at the time, c	n, State) cause(s) a	and manner as	stated. to the cause(s)

State of Maryland / Department of Health and Mental Hygiene 🤈 🗍 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Month **Physician** 3, 2006 12:01 a M Lisa K. Ford June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Baltimore Futurecare Cherrywood Reisterstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 270 F Yrs. 214-86-0401 42 1963 Maryland Nov. 6, Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show r than "natural", or itema 23a or 28a-f shov tre Medical Examiner must be notified at 1 ☐ Yes 2X No Director Hampstead MD Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21074 1017 South Carroll Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: <u>م</u> White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and 2 should be filed within 7 alth and Mental Hygiene.
127 is marked other than "r ar traumatic svent, trau College (1-4or 5+) Elementary/Secondary (0-12) Own Home Housewife 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Shirley Frielander Harris Stanley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) s 1 and 2 st of Health ar J. Itsm 27 is or other ter Hampstead, MD Husband 1017 South Carroll St. Dennis J. Ford 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: if its
sny injury or ot 1 ₺ Burial 2 Cremation 3 Removal from State 6/7/06 Reisterstown, MD All Saints Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 11824 Reisterstown Road 21. Signature of Funeral Service Licenses enteus 21136 Reisterstown, MD Eline Funeral Home Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Juntington Minery disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires thet the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Dav 5 ☐ Other (specify) 4☐Pregnant at time of death P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 Yes Division of Vital funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending Injury To the nospino within 24 hours after death.
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 9 the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie ans 30. Name and address of person ompleted cause of death (Item, 23a) (Type, Print) Men eman Coaste 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar

	•	For State Registrer		Warytark		tificate o			ygiene Reg. No.	06	17698
Discontinuity		1. Decedent's Name (First, Middle	, Last)					2. Date of D	Day	Year	3. Time of Death
Physicia /Medica		Milton J. Fabi	szak					June	15.	ZOUO	6.00A,
Examine	er	4a. Facility Name (If not institution,					n, or Location of D	eath		ty of Death	
		Baltimore Wash 5. Social Security Number		lical Ce 7. Age (In yrs. Ia		Glen I	Burnie ar If Under 24	Hrs. R Date of F		Aruno	del lace (State or Foreig
Funeral Director		213–20–1740	18 M 2□F	82	Yrs.	Months Day		Min. (Month, L	2/1924	Coun	riy) Vland
		Usual Residence of Decedent		02				00/02	2/ 1924	Plat	y Lana
how		10a. State 10b. County		10c. City	, Town or Lo	cation				1	Od. Inside City Limit
within 72 hours after death with the Maryland one. than "netural", or Itams 23a or 28a-f ahow is Modelle Exempter in wat the notified at	cto	Maryland N	/A	Ba.	Ltimor	e					1 Yes 2 N
or 28	Olre	10e. Street and Number				10f. Zip Code	9		10g. Citizen o	f What Coun	try?
ath w	ral	2108 Boston Str				2123		0.40	United		
In rainous arier uean winture waryan "netural", or Itams 23a or 28a-f ahow walical Examinat must be notified at	Funeral Director	11. Marital Status	12. Was Deced	ces?	5. 13. 1	vas Decedent of f Yes, specify C	of Hispanic Origin uban, Mexican, P	? (Specify Yes or I uerto Rican, etc.)	No- 14. Ha	ace - Americ ack, White,	
, o	byF	1 ☐ Never Married Marri 3 ☐ Widowed 4 ☐ Divorced	led 1 Yes 1 If Yes, Give Year or Da	tes: WWI		I□Yes 2	No Specify:		Spec	ity: Wh.	ito
etura	ted	15. Decedent	's Education	AAAAT-	16a. Deced	lent's Usual Occ	cupation		16b. Kind of		
Man .	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-	4or 5+)	(GIVe	kind of work dor DO NOT use ret	ne durina most oi	working			
	Com	10		,	Butc	her			Whole	sale I	rood_
d other than	Be (	17. Father's Name (First, Middle, I	Last)				18. Mother's	Name (First, Midd	le, Maiden Suma	ime)	
	P	Andrew Fabisza						nela Dzir			
a se		19a. Informant's Name/Relationsh						r Rural Route Num			,
f Health itam 27 other tra		Pauline Fabisza	k - Wife	20h PI		Boston sition (Name of		Apt. 408	Baltimo 20c. Location		
if its		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 Removal from S	tate	metery, cren	natory or other p	olace)				
Department of Important: if any injury or once.		'4 □ Donation 5 □ Other (Sp.		Bay	view o	Cremato	ry 0	6/06/2006	5 Baltim	ore, M	Maryland
Depar Importany ir any ir		21. signature of Fulleral Selver t	13/1		Ď	avid J.	Weber F	Uneral Ho treet Bal	mes P.A	•	7 24 22
Departr Importa any inj		23a. Part 1. Enter the disease or	complications that ca	used the death	. Do not ent	or the mode of d	Nester S tving such as cal	treet Bal	arrest.	Mary.	Approximate
		23a. Part1. Enter the disease or shock, or heart failure. List temmediate Cause (Final	only one cause on ea	ch line.	- 1	TA Y	60	1-			Interval Between Onset and Death
iysician Medical		disease or condition resulting in death)	aDue to (	as a consequ	ones of	Attente	W	hhy			
aminer			Due to (	as a consequ	ence or):	UL					
1	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (d	or as a consequ	ence of):						
sician and burial-transit	Examiner	Cause (Disease or injury that initiated events	С								
		resulting in death) Last	Due to (d	or as a consequ	ence of):						
> =	lcal		d								
afor use as the t	Physician/Medi	IF FEMALE:	23c. If yes, outo	ome of progna	201						
for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live bi	th 2 ☐ Fetal ant at time of de	death 3	Ectopic pregnal Other (specify)				ate of delive Ionth	ry Day Year
ed by the detached	ysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unkno			, Gillar (Speeliy)					
		Part II. Other significant condition	ens contributing to de	ath but not resu	lting in the u	nderlying cause	given in Part I.	23e. Dio	I tobacco use cor	ntribute to th	e cause of death?
n sign	d by							1	Yes 2XNo	3 🗆 Prob	ably 4 Unknov
s been si	Completed							24a. Wa		. Were autor	osy findings availat
has ge 2	ошь							per	opsy formed? 2 X No	prior to con death? 1 \( \text{Yes}	nptetion of cause o
age	O	25. Was case referred to medicat					26. Place of	1 ☐ Yes  Death (Check only		1 1 1 1 1 1 1 1 1	2 140
tificate ha	ø	examiner? 1 ☐ Yes 2 No	Hospital:	patient 2 🗆 l	ER/Outpatien	t 3 DOA	Othor	ng Home 5 ☐ Re		ther (Specify	)
s certifi	o Be			f Injury	28b. Time of Injury	V			how intury occu		
fter this certifi	To Be	27. Manner of Death  1 Natural 5 Pending	9	, Day Year)						har as Cina	
fter this certifi	To Be	1 Natural 5 ☐ Pending 2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	g (Month gation not be 28e. Place	of Injury - At ho	me, farm, str	eet, factory, offic	28	28f. Location	(Street and Num	iber or Hural	Houte Number,
fter this certifi	To Be	1 Natural 5 ☐ Pending	g (Month gation not be 28e. Place		me, farm, str		DB	28f. Location City or T	(Street and Num own, State)	ider or murai	Houte Number,
4 hours after death.  *Unaral Director: After this certifically filled in by the funeral director.	al Certification; To Be	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only 2 Medicel I	g (Month pation not be ined 28e. Place buildin  g Physicien: To the Examiner: On the ba	of Injury - At ho g, etc. (Specify best of my knownsis of examinat	) vledge, death	eet, factory, office	time, date and p	City or T	own, State) e cause(s) and m	nanner as st	ated.
thours after death.  Funaral Director: After this certificate filled in by the funeral director.	Certification: To Be	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)	g (Month pation ont be ined  28e. Place buildin  g Physicien: To the Examiner: On the ba and mann	of Injury - At ho g, etc. (Specify best of my knownsis of examinat	) vledge, death	eet, factory, office occurred at the vestigation, in m	time, date and p	City or T	own, State) e cause(s) and m	nanner as st	ated. the cause(s)
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4 hours after deathunaral Director: After this certifielt filled in by the funeral director.	edical Certification: To Be	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier 30. Name and a less of person of the content of the certifier	g (Month pation of the building Physicien: To the Examiner: On the ba and mann who completed cause	of Injury - At ho g, etc. (Specify best of my knov sis of examinat er stated.	viedge, death	n occurred at the restigation, in m	e time, date and p y opinion, death o	City or T	own, State) e cause(s) and makes, date and place	nanner as st	ated. the cause(s)
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within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Certification; To Be	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier 30. Name and a Ness of person of the control of the control of the control of the certifier	g (Month pation of the building Physicien: To the Examiner: On the ba and mann who completed cause	of Injury - At ho g, etc. (Specify best of my know sis of examinat er stated.	vledge, death ion and/or inv 23a) (Type,	n occurred at the restigation, in m	e time, date and p y opinion, death o	City or T	own, State) e cause(s) and makes, date and place	nanner as st	ated. the cause(s)

Registrar

DHMH 17 Rev 1/2001

State

32. Resistrar's Signature

2401 W. Belvedere Ave.

Balt. Md. 21215

30. Name and address of person who impleted cause of death (Item 23a) (Type, Print)

charlotte Elicksman, mo

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2 [] [] [ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2:30 A Month **Physician** Curtis Friel 2006 June 1, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a Future Care Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 12 M 2□F 68 234-58-0808 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.
the rhan "natural", or tems 23s or 28s-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23s or 28s-f ehow The Medical Exercit or most be cottified at 1 Yes 2 No Baltimore Lansdowne Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 321 1st Ave 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Specify: White þ 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Recycling Sheet Metal Pages 1 and 2 should be filed vent of Health and Mental Hygie int: If tem 27 is marked other t 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be unknown Edna Friel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Gurski / daughter 321 1st Ave Lansdowne, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal Irom State Glen Haven Memorial June 5, 2006 Glen Burnie, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fune 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd Lansdowne, Maryland 21227 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine ettending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4 Pregnant at time of death Day 5 Other (specify) signed by the e 1 Yes 2 No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 Yes 2 No 1 Yes 25 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifice completely filled in by the funeral director. p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Suursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) PHYSICIAN 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) SANDHU 1940, ALTIMORE 17 BALTIMORE MP 21223 W. 31. Date liled (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 15, Physician 2006 Forrest Griffith 3:46 p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 6601 N. Charles Street Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. July 2, 191 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Yrs. 078-07-3244 Director 87 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or Items 23e or 28a-f show the Medical Evantings must be multiped at 1 ☐ Yes 2√ No Director Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2525 Pot Spring Road K 409 21093 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 XYes 2 ☐ No Il Yes, Give Year or Dates: \$41-46 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Executive Manufacturing 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Health and Mental is marked Forrest L. Griffith, Sr. Myrtle Elizabeth Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Fages 1 and 2 Department of Health at important: If item 27 is any injury or other trau. Elizabeth Griffith/wife 2525 Pot Spring Rd. K 409 Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State · 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ronald State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Part1. Enter the disease, or comclications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. 23a. Part1. Approximate Interval Between Onset and Death Immediate Cat se (Final disease or condition resulting in death) Scheme Cardonyopuny jears Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 Yes 2 7No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA After th 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural Injury 5 Pending hours after death uneral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D58303 16 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4001 N. CHARLES STREET

DHMH 17 Rev 1/2001

State

Registrar

2. Registrar's Signature

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1 OWSON MD

ATRON J. CHARLIES, UD

JUN 0 6 2006

31. Date filed (Month, Day, Year)

Docation Parkville  10f. Zip Code 21234  Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, II Yes 25 No Specify: Indent's Usual Occupation Is kind of work done during most of DO NOT use refured)  18. Mother's Bern: Ing Address (Street and Number Old Harford Roosition (Name of	Death  M  4 Hrs.  8. Date of Birth  Aug.  10g  10g  10g  in? (Specify Yes or No-Puerto Rican, etc.)  col working  16i  Con Rural Route Number, Cond-Parkville  Date  200  P  Tune 8,2006  P	. Citizen of What Coun USA  14. Race - Americ Black, White, Specify: Wh. company iden Sumame)  ity or Town, State, Zipe, Maryland c. Location - City or To	lace (State or Foreign In Indian, etc. ite dustry and Seal y Cordel
Timonium  If Under 1 Year If Under 24  Months Days Hours  Docation  Parkville  101. Zip Code 21234  Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, III Yes, specify:  In Yes 25 No Specify:  In Yes 25 No Specify:  In Yes 25 No Specify:  In Yes 25 No Specify:  In Yes 25 No Specify:  In Yes 25 No Specify:  In Yes 25 No Specify:  In Yes 25 No Specify:  In Yes 25 No Specify:  In Yes 25 No Specify:  In Yes 26 No Specify:	M 8. Date of Birth Aug. 10, 1  In a line (Specify Yes or No-Puerto Rican, etc.)  So Name (First, Middle, Marice Booth  Tor Rural Route Number, Cood—Parkville  Date 2006  P	Baltim  9. Birthp Penris  1. Citizen of What Coun USA  14. Race - Americ Black, White, Specify: Wh. b. Kind of Business/inc rown, Cork, Compan iden Sumame)  city or Town, State, Zip e, Maryland c. Location - City or To	lace (State or Foreign In Indian, etc. ite dustry and Seal y Cordel
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ostion (Name of majory or other place)  Cemetery  June 2. Name and Address of Facility	Date Date 2006 P	e,Maryland c. Location - City or To	<sup>Code)</sup> 21234
Cemetery J1  2. Name and Address of Facility	une 8,2006 P		
	EVANS CHAI		,Maryland
	Road-Parky	/ille,MD	21234
iter the mode of dying, such as ca	ardiac or respiratory arrest		Approximate Interval Between Onset and Death
□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
underlying cause given in Part I.		cco use contribute to the	ne cause of death?
	24a. Was an autopsy performe 1 ☐ Yes 2X	d? prior to cor death?	psy findings available inpletion of cause of
1 Out	of Death <i>Check only one</i> sing Home 5 Residence	e Violes (See )	. HOCDICE
of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how	injury occurred	
th occurred at the time, date and	City or Town, S		
nvestigation, in my opinion, death	n occurred at the time, date	and place, and due to	the cause(s)
29c. License number		6 /5/00	
	UM, MD 21093		
_	29c. License number  29c. Print)	29c. License number 29d  D73725  pe, Print)	29c. License number 29d. Date signed (Month, pe, Print)

JUNE 5, 2006 3:50 a.m.

WILLIAM GERHARDT

			1 - For Registrar	State of N	Maryland / De	epartme Certifica				lental Hy	giene	/ 11	06	17703
	Di cici		1. Decedent's Name (First, Middle, L	.ast)						2. Date of De	ath Day	, ,	Year .	3. Time of Death
	Physici /Medio		Steven Lucke	Gonder						June	02,	_200	)6	4:25 A. M
Н	Examir	er	4a. Facility Name (If not institution, g		er)			r Location of	of Death			County of		
_			Gilchrist Hos  5. Social Security Number 6.		Age (In yrs. last birth)		WSON er 1 Year		24 Hrs.	8 Date of Bir		alti	mor	e County
	Funeral Director		213-66-8240 Usual Residence of Decedent	1 <b>⊠</b> M 2□F	51 Yr	Month		Hours	Min.	8. Date of Bir (Month, Da Octobe				place (State or Foreign htty) timore, MD
	yland		10a. State 10b. County		10c. City, Town o	or Location							1	0d. Inside City Limits
	Man Hed	tor	MD. Baltim	ore Co.	Timon	ium								1 □ Yes 2 XNo
	or 28	Oire	10e. Street and Number			10f. 2	ip Code				10g. Cit	izen of Wh	nat Cour	ntry?
	within 72 hours after death with the Maryland ane. than 'natural', or items 23e or 28e-1 show he Madical Exami at must be notified at	Funeral Director	3 Dalecrest C	ourt Ap	t.303	12 Was Day		21093		neifu Van as Na	Uni	ted		tes an Indian.
10	ter de	Fune	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Force				an, Mexican	n, Puerto	ecify Yes or No Rican, etc.)	,.		White,	
99	al', o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Date		1 🗆 Yes	2 X No	Specify:				Specify:	Wh	ite
21215-0036	72 hc	Completed	15. Decedent's (Specify only highest of		(0	ecedent's Us	vork done	during mos	t of work	ing	16b. Ki	ind of Bus	iness/In	dustry
121	within ne. than	mpi	Elementary/Secondary (0-12)	College (1-4d	or 5+)	fe. DO NOT		•	D	1.	Rı	roke	r	
d 2	filed v Hygie other i		12 17. Father's Name (First, Middle, Lat	02	Sei	f Emp	, / Sa			Ker e (First, Middle				
Maryland	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event. The Mudical Examinat must be notified at ance.	To Be	Daniel Boggs	Gonder				Eliz	abe	th L.	Luc	ke		
lan	2 sho and h is ma	•	19a. Informant's Name/Relationship	(Type, Print) ( W	TIE)					al Route Numb				
<u>ک</u>	lend lealth im 27	1	Mrs. Sandra K	ay Gonde	r 3			Ct.		.303 T			_	
וסר	if ite		20a. Method of Disposition 1 Burial 2 Cremation 3		nomoton:	crematory o	other plac			/2006		cation - C	•	
Baltimore,	artmer ortant injury		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		~ /	22. Name	and Addre	ss of Facilit	tv					,Maryland
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			23a. Part J. Exter the disease, or co sheck, or heart failure. List on	mplications that causely one cause on each	sed the death. Do not h line.	t enter the m	ode of dyin	g, such as	cardiac	or respiratory a	rrest,			Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a. <u>(Si</u>	yhayen	L C	Are	W						rentus
	/Medical Examiner		Todaling in doding	Due to (or	as a consequence of)	:								
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or	as a consequence of									
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Ő,	ate be executed obysicien and the burial-transit	Exc	resulting in death) Last		as a consequence of)									
8760,	death certificate be executed e attending physicien and nd for use es the burial-transit	Physician/Medical	•	d									-	
9 X	leath certifica attending ph I for use es th	/Me	IF FEMALE:	23c. If yes, outcor	me of pregnancy							23d. Date	of dollars	200
Вох	death a atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)	4☐Pregnant	2 Fetal death t at time of death	3 ☐Ectopic 5 ☐ Other (					· ·	Montl		Day Year
P.0.		hys	9 Unknown	9□ Unknowr	1									
	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions	contributing to death	h but not resulting in th	ne underlying	cause giv	en in Part I.		1		M		ne cause of death?
ord	requir een si nould	ted								10	Yes 2	No 3	Prob	ably 4 Unknown
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a F	n: The licate ha		OF IMage and a standard to an elicate							1 Yes	2 XX No			2□ No
₹	s certi	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital: 1 Inpa	atient 2 ER/Outp	atient 3 1	Oth	05		n <i>(Ch</i> ec <i>k only o</i> me 5 ⊟ Resi		c Hanne	/Canada	phaspice
o c	Attending Physicien: r death. sctor: After this certificator. By the funeral director.		27. Manner of Death	28a. Date of le		ne of	28c. Injun Work			28d. Describe				majria
Ö	andin ath. or: Aft he fun	atio	Natural 5 Pending investigat	ion	Day roar) Inju	M		Yes 2 ☐ i	No					
Division of Vital Records,	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	ad 289. Place of	Injury · At home, farm etc. (Specify)	, street, fact	ory, office			28f. Location ( City or To			or Rura	l Route Number,
_	To the Hospitel or Attending Physicien: The I within 24 hours after death.  To the Funarel Director: After this certificate his completely filled in by the funeral director, page	edicai Ce	29a. Certifier Sertifying	Physicien: To the be	est of my knowledge, of examination and/o	death occurre	d at the tin	ne, date an	d place,	and due to the	cause(s)	and manr	ner as st	ated.
	To the h within 24 To the F complete	Medi	one)	and manner	stated.		9c. Licens			33 at 1113 tanto,				
	on To with		29b. Signardre and title of certifier	1					2					Day, Year) 2-006
,	7		30. Nar e and address of person wh	o completed cause /	of death (Item 23a) /To	(De. Print)	- /	2 /0	)	-	57		0.	
	6		AMON Ch	ules m	D 6601	N,C	la	rles	$S_{i}$	+ B7	414	nore	n	2006 10 21204
	Sta Regist		31. Date filed (Month, Day, Year)  JUN 0 6		istrar's Signature	Spente	آر							7

**ORIGINAL** 

4:25 Am

6/2/06

Gonder, Steven

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 0920 M 2006 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1☐M 2□F Months Days Hours Yrs. 219-92-0381 June 1, Georgia Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Md. Harford Bel Air 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1405 Loch Carron Way U.S.A. 21015 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: white Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Cottege (1-4or 5+) Elementary/Secondary (0-12) carpenter construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard Greene Mary Kathryn Allman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Gentry/sister 1405 Loch Carron Way, Bel Air, Md. 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 € Other (Specify entombment Lorraine Park Cem. 6/5/2006 Baltimore, Md. 21. Signature of neral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finat 12hrs INTESTINAL disease or condition resulting in death) Due to (or as a consequence of) DIVERTICULOSIS ENLEPHALOPATH HEPATIL Due to (or as a consequence of) SEPSIS IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ULITIS 1 Yes 2 No 3 Probably 4 Unknown

**Physician** /Medical Examiner

Physician/Medical

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Certification; To

Medical

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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and Mental

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 le eny injury or other trau once.

Baltimore,

Division of Vital Records, P.O. Box 68760

FOX TO MENONERS

Director

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Completed

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

24a. Was an autopsy performed 1 ☐ Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 2 1 NO 1 Yes

25. Was case referred to medical 1 ☐ Yes 2i ☐ No 27. Manner of Death

Hospital: 1 Thipatient 28a. Date of Injury (Month, Day Year) 5 Pending

26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of

28d. Describe how injury occurred

Watural investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number 1241080 29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
1205, CHURCHVILLE Red., BOLAR 1208, CHURCHVILLE

Archana Sood, M.D.

612/06

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

JUN 0 6 2006

Lihava .



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DHMH 17 Rev 1/2001

within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director,

or Attending

Location State (Prince State)   Location State (Prince State			-	For State Registrar	State of Marylai		artment of H		nd Mental H	ygienę Reg. No.2	06	17706
TOTAL TOTAL STATE AND CONTROL TO A STATE OF THE CONTROL OF THE CON			an	1					Month	Day	Year	
## RIDERROOD VILLAGE RENAISSANCE GARDEN    Fundamental Control   Size Season's Manager   Size   Si			-	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of		4c. Coun	ty of Death	<del></del>
Use Facilities of Decorate 1 To Location				RIDERWOOD VILLAGE								
Description of the property					711 000				Min. 8. Date of Month 04/2	6/1925	9. Birthp	place (State or Foreign ntry) NJ
BENDAMIN  GRESHON  GR		D.			10c. C	ity, Town or Lo	ocation				1	0d. Inside City Limits
BENDAMIN  GRESHON  GR		a-faho	ctor	MD MON	ΓGOMERY	SILVE	R SPRING					1 No Yes 2 No
BENDAMIN  GRESHON  GR	55 	with th	Dire		20AD #US 210		10f. Zip Code	2000/		10g. Citizen o	f What Cour	
BENDAMIN  GRESHON  GR		ns 23	era		12. Was Decedent Ever in t	J.S. 13.	Was Decedent of H		n? (Specify Yes or	No- / 14. Ra		can Indian,
BENDAMIN  GRESHON  GR	36	or ften	y Fun	1 ☐ Never Married 2 💢 Married	Armed Forces? 1 X Yes 2 ☐ No If Yes, Give				Puerto Rican, etc.)			
BENDAMIN  GRESHON  GR	00-	2 hours aturaf	ted b	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	ation	of warding	16b. Kind of	Business/In	dustry
BENDAMIN  GRESHON  GR	1215	ithin 7: ne. han "n	mpie		College (1-4or 5+)			au <i>ring</i> most o	or working	V C C O II V	ITING	
Second   Continued   Continu		Hygier Hygier ther ti		17. Father's Name (First, Middle, Last)	4	ACCOU	INTANT	18. Mother's	s Name (First, Mide	1111111		
Second   Continued   Continu	/lan	viid be Viental vrked o	To Be			GERSH	ION					GREENBERG
Second   Continued   Continu	Mary	12 sho h and l 7 is me traume		, ,			,					
BETH ISRAEL CEMETER!   06/04/2006   WODDBRIDGE. NJ		f Healt item 2 other		20a. Method of Disposition	20b.							
23a Part. Enter the disease, or complicationsplate activised this Death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate clause Final immediate Cause Final Immediate	imo	Page nent o ant: If ury or		*4 □ Donation 5 □ Other (Specify	) BE							
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9 Unknown  1	x 68	entifica ding ph se as th	/Med		23c. If yes, outcome of pregr	nancv		-		224 [	ate of deline	no.
DOY TO THE PROPERTY OF THE PRO		death of atten	ician	in the past 12 months?	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	tal death 3[		/				•
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1   Yes 2   No 1   The part of the part of	a R	ate pag							1 □ Ye	s 2 No		2 No
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28f. Location (Street and Number or Rural Route Number, building, etc. (Specify)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  30b. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30b. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30b. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30c. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30c. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30c. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30c. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30c. Name and address of person who completed cause of death (Item 23a) (Type, Print)	of		$\vdash$	27. Magner of D ath		28b. Time o	ol 28c. Injur Wor	y at	28d. Descrit			<i>y</i> /
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. (C) Ar FIETO KORD DILVER SPRING MI) 20904		To the within To the compl	Me	29b. Signature and title of certifier	1. 4.	· · · · · · · · · · · · · · · · · · ·	29c. Licens	e number		29d. Date sign	ned (Month,	Day, Year)
10 310 CHAREFIELD ROAD DIEVER DERING MI) 20904				- Jalla p/	REMINIY)	02-\ C*		375		16/2/0	٢	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		[0]		1 2 4	ELD KOAD	DILVE	TL DERIN	a, LIC	20904	1 1		
		St Regist			32. Redistrar's Sig	nature	Societies					

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			1 - For State Registrar	State of Mai	-	partment o <i>ertificate d</i>			giene/_ Reg. No.	UUb	1//0/			
		38	1. Decedent's Name (First, Middle, Last	)				2. Date of De Month	ath Day	Year	3. Time of Death			
	Physici /Medio		Virginia Hird	MAY	26	5008	Z:00 PM							
	Examir	her 4a. Facility Name (If not institution, give street and number)  SINAL HOSPITAL OF BALT! MORE  5. Social Security Number  6. Sex  7. Age (In vrs. last birthday)  If Under 1 Year  If Under 24 Hrs. 8. Date of Birth  9. Birth												
	Funeral Director		037-22-0250	314 087 5	(In yrs. last birthda 4 Yrs	Months Da			y, Year)	9. Birthp Coun Mary				
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. In											
	Maryl f sho	Į,	MD		Baltimor	••					1 ∑Yes 2 □ No			
	r 28a	irec	10e. Street and Number		Dartimor	10f. Zip Cod	ie		10g. Citizer	of What Coun	try?			
	23a o	ai D	7474 Washington I	31vd		21227	7		USA					
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23s or 28s-f show or other traumatic event, the Medical Evanting that this Item Collins of an other traumatic event, the Medical Evanting that this Item Collins of an other traumatic event, the Medical Evanting that the Collins of an other traumatic event, the Medical Evanting that the Collins of an other traumatic event, the Medical Evanting that the Collins of the Collin	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	1127	3. Was Decedent Il Yes, specify (	of Hispanic Origin? ( Cuban, Mexican, Pue No <i>Specify:</i>	Specify Yes or No into Rican, etc.)		Race - Americ Black, White,				
21215-0036	Mural		3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edu	Year or Dates:	16a. De	cedent's Usual Oc	ecupation		16h Kind	whi of Business/Inc				
215	an" na	piet	(Specify only highest grad	le completed)  College (1-4or 5+)	(G.	ve kind of work do DO NOT use re	one during most of w	orking	TOD. THING	or basinosa inc	Justiy			
212	filed with Hygiene other the	Completed	unk ur		RN				Healt	hcare				
nd	2 should be filed withir and Mental Hygiene. Is marked other than surnatic event, tre Ms	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle,	Maiden Su	татө)				
γ	should ind Men marke umatic	2	Harold W. Crane	una Beinel	10h M	Ulina Andriana (Ca	Helen W		- 0'tT					
Maryland	d 2 st th and th and traur		19a. Informant's Name/Relationship (T)		1		eet and Number or F				Code)			
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra <u>once</u> .	1	John Francis Hird, Sr./spouse 7474 Washin, ton Blvd. Baltimore, MD 21227  20a. Method of Disposition  1											
Baltir			21. Signature of Edmard Service Licensee Ronald S Wade, Olrector State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201											
			23a. Part Enter the disease or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between											
ı	Ifficate be executed  g physician and as the burial-transit		Immediate Cause (Final disease or condition resulting in death)  List only one cause on each line.  CARDIAC ARREST  Due to (or as a consequence of):											
				7	O JERRE									
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):										
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30,	oe execian a		resulting in death) Last	Due to (or as a	consequence of):									
68760,	physic	edicai		d.										
.O. Box 6	The law requires that the death certificate be executed the sbeen signed by the attending physician and otge 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown		23d	. Date of delive Month	ry Day Year						
Δ,	uires that n signed by lid be deta	þ	Part II. Other significant conditions co	ntributing to death but	not resulting in the	underlying cause					acco use contribute to the cause of death?			
Records,	sician: The law requir certificate hes been si irector, page 2 should	Completed				-		24a. Was autop		4b. Were autop prior to con death?	osy findings available inpletion of cause of			
Vital	an: Ti lificate or. pa	ပိ	25. Was case referred to medical				26 Place of De	1 ☐ Yes		1 🗆 Yes	2 <b>X</b> , No			
Ξ	Physician: this certific ral director,	0 8	examiner?	Hospital: Inpatient	2 ER/Outpat	ient 3 DOA	O#- = =	Home 5 Resid	77	Other (Specify	•)			
ion of	ttending Physical death.	ation: T	27. Manner of Death  Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)	28b. Time	e of 28c. I	njury at Work? 1 □ Yes 2 □ No	28d. Describe h			,			
Division	or A fter Sire in by	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	/ - At home, farm, (Specify)	street, factory, off	ce	281. Location (S City or Tow	Street and N vn, State)	lumber or Rural	Route Number,			
	To the Hospital within 24 hours a To the Funeral I completely filled		29a. Certifier 1 Certifying Phy	sician: To the best of ner: On the basis of e	my knowledge, de	ath occurred at th	e time, date and place	e, and due to the	cause(s) and	d manner as sta	ated.			
	To the H within 24 To the F complete	Medical	one)	and manner state	d.									
	Viit To Con	2	29b. Signature and title of certifier	modani			ense number ES ~ 000		29d. Date si	igned <i>(Month, E</i> フら フ	Day, Year)			
			30. Name and address of person who co	omple ed cause of dea	th (Item 23a) (Typ	e, Print)				-				
	VE		ENGENIO CIN		MT		HOSPIT	AL OF	BAC	LIMORI	2			
	Sta Registi		31. Date filed (Month, Day, Year)	32 Registrar	s signature	parte								

PATIENT KNOWN AS VIRGINIA HIRT

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death 3. Time of Death Q 1. Decedent's Name (First, Middle, Last) Month 10:07 **Physician** 21 2006 William Hartpence /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 6 Sex **Funeral** 1 X M 2 □ F New Jersey Jan 15, 69 152-28-7979 Director Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or iteme 23a or 28a-f show eny injury or other traumatic event, the Mandical Exculper must be notified at once. 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No by Funeral Director Hagerstown Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 16901 Pickwick Lane Lot 296 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces?

1 25 Yes 2 □ No
II Yes, Give
Year or Dates: 154-62 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Baltimore, Maryland 21215-0036 white 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk Elementary/Secondary (0-12) College (1-4or 5+) TV Technician 12 none 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Flora Jane Lant Earl Clarence Hartpence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16901 Pickwick Lane Lot 296 Hagerstown, MD 21740 Ruth Hartpence/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signature of Tuneral Service Licer Ronald S Wade Vi Baltimore, MD 21201

23a. Parti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line Approximate Interval Between Onset and Death neumonia Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Renal Disease Examiner End Stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Encephalopathy Physician/Medical Examiner Metabolic The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ettending physician IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ò 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached it 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? has 1 ☐ Yes 2 ☐ No 1 Yes 2 No certificate Hospitei or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) director, Be Hospital: 1 Hopatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 1 ☐ Yes 2 ☐ No 2 ER/Outpatient Certification: To hours after death. Ineral Diractor: After this y filled in by the funeral d this 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospitel within 24 hours a To the Funeral C completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time date and lane, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D060396 05/22/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) opa1 1126 Hagerstown MD 21740 MURSHED FARID 22. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUN 0 6 2006

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene Mildred Cecelia Henderson

		1- For State Certificate of De	ath	73		. No. 20	06 1770			
Physicia Medical Exami		1. Decedent's Name (First, Middle, Last)			Date of Death Month	Day Year	3. Time of Death 1615 hrs			
vieulcai Exami	i iei	Mildred C. Henderson  4a Facility Name (if not institution, give street and number)  4b. Ci	ty, Town, or Loc		lay 30, 200	4c. County of De				
			nite Marsh			altimore				
Funeral					Date of 8irth	(MM/DD/YYYY) 9.	8irthplace (State or			
Director		219-42-2164   1 M 2 X F   84 Yrs.   MC	onths Days	Hours Min.	Oct. 2,	, 1921	reign Country) <b>Maryland</b>			
<b>x</b>	ļ	Usual Residence of Decedent								
w any		10a. State 10b. County 10c. City, Town or Location	1				10d. Inside City Limits  1 Yes 2 No			
Aaryland 28a-f show I at once.	į	Md. Baltimore White Ma	Zip Code		100	. Citizen of What C				
th the Maryland 23a or 28a-f sho notified at once.	Director	5629 Allender Road	211	62	109	U.S.A.	ountry?			
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leath wi	Funeral			exican, Puerto Ric		White, etc				
after o	by F		2 No sp	pecify:		Specify <sup>-</sup>	white			
hours afte 'natural'', Examiner	P P	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Us during most of		(Give kind of work NOT use retired)		6b. Kind of Busine	ss/Industry			
036 Ithin 72 ne. r than " ledical	Completed	Elementary/Secondary (0-12)  12 years  College (1-4 or 5+)  homemake	r		1	own hom	.e			
15-0036 filed within Hygiene. d other tha	틧	17. Father's Name (First, Middle, Last)	18,1	Mother's Name (Fir	st, Middle, Ma	iden Surname)				
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	George H. Kinlein	,	Emma Ger		-				
y, MD 21215-0036 and 2 should be filed within 72 leath and Mental Hygiene. tem 27 is marked other than "traumatic event, the Medical	٩					er, City or Town, Si				
e, MD I and 2 sho Health and item 27 is	ŀ	20a. Method of Disposition 20b. Place of Disposition (	Name of cemete			20c. Location - City				
<b>5</b> 8 8 = 8		1 XBurial 2 Cremation 3 Removal from State crematory or other plants Bel Air Mem.		6/2/	2006	Bel Air,	Md.			
Baltimc permit Page Department of Important: injury or otd	ł	4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee 22. Name :	and Address of I	Facility						
Balt permit Departi Importinjury	- 1	Busin a lelle Sch	imunek l	Funeral l Phail Ro	Home of ad. Rel	Bel Air Air, Md				
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mo failure. List only one cause on each line	de of dying, suc	h as cardiac or res	spiratory arrest	t, shock, or heart	Approximate Interval Between Onset and			
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of)	cular Disea	se			Death			
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	ě	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause								
	aminer	C. Due to (or as a consequence of):								
cuted .nd transit	EX	d								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.	Physician/Medical	UNPENDED X AMENDED item#4c,perME,G856,	6/6/06 TI							
760, ficate be g physici	/Me	F FEMALE: 23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal de:	2 1	Ectopic pregnancy		23d. Date of deliv				
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S, F quires an sign	ed						Probably 4 Unknown			
cords, law requir has been s	plet				24a Was an autopsy perform	prior	autopsy findings available to completion of cause of			
Rec The l	Completed				1 Yes 2					
Ital Recionary The scentificate	Be	25. Was case referred to medical examiner? Hospital: 4 leasting 2 FD/Output at 1	Oth	Death (Check only						
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Division of Vital Records, P. Int or Attending Physician: The law requires the rs after death.  al Director: After this certificate has been signe led in by the funeral director, page 2 should be do	Ē	1 Natural 5 Pending (Month, Day, Year)	1 Yes			,,				
/iSic r Atte ter dez irrecto	ţį	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fact	ory, office buildi	ing, etc. 28f			Rural Route Number, City			
Divis Hospital or A 4 hours after Funeral Dire tely filled in b	Certification:	4 Homicide determined (Specify)			or Town, Stat	te)				
e Hos of Hos e Fun letely		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at								
To the Ho within 24 P To the Fu	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated								
_	2	29b Signature and title of certifier	29c. License nu O.C.M.E			?9d Date signed <i>(i</i> <b>May 31</b> , <b>2006</b>	Month, Day, Year)			
1		30. Name and address of person who completed cause of death (Item 23a)	J.J.IVI.L			a, 01, 2000				
15		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Sti	eet, Baltimo	ore, MD 21201						
	tate	31. Date filed (Month, Day, Year)  32. Registrar's Signature	,							
Regis	trar	JUN 0 6 2006 / Marca 19 My								

	1 - For State Registrar  1. Decedent's Name (First, Middle, Last)	State of Maryland	/ Departme			d Mental H	Reg. No.	06	3. Time of Death
Physician /Medical	Carolyn R. Harrison JUNE 2, 200								
Examiner	Saint Joseph M	Medical Cent	er			vson		Balt	imore
Funeral Director	5. Social Security Number 6. Sex 214-80-7066	7. Age (In yrs. las	Yrs. If Undi	Days	Hours	Min. (Month, L	Birth Day, Year) B / 1943		lace (State or Fore stry) Yland
a-f show	10a. State 10b. County	-	Town or Location Baltimor	·e			-	1	0d. Inside City Limi
with the Mar		oad	10f. Z	p Code 212	34		10g. Citizen of V		itry?
72 hours after death with the Maryland nature!; or items 23s or 28s-f show lical Examinant te notified at eted by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1		Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto R				e - American Indian, k, White, etc. White	
ed within 72 hor ygjene. ner then "natura it, I're Madica E Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)							Business/Industry	
tal H od oth	17. Father's Name (First, Middle, Last)	Perrone	Homem		18. Mother's	Name (First, Middle Ruth Sl	,		:e
permit. Pages 1 and 2 should Dependent of Health and Mer Important: If item 27 is marke eny injury or other traumatic once.	19a. Informant's Name/Relationship (Ty.  Robert Harris  20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)  21. Signature Anneral Service License	son - spouse  emoval from State  20b. Plac	or elan Or elan 22. Name a	cton  me of other place  and Address	Rd.	Baltimo Date -8-06 Chapel	re, MD 200 Location 8800	2123 City or To UI   (e) Harf	4 wn, State
death certificate be executed  e attending physician and d for use as the burial-transit  clician/Medical Examiner		Due to (or as a consequent of the to	nce of):						5 YEARS
that the death certificate be ed by the attending physici detached for use as the bu	IF FEMALE: 23b. Was decedent prednant in the past 12 prinths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deal	eath 3 Ectopic				23d. Dati Mor	e of delive	ry Day Year
igne d	Partitioner significant conditions con	atributing to death but not resulti	ng in the underlying	cause give	n in Part I.	1	Yes 2 No	3 ☐ Prob	ably 4 ∏Unkno
certificate hes been s rector, page 2 should						per 1 🗆 Yes	opsy formed? d 2) No 1	rior to cor eath?	osy findings availa npletion of cause i 211 No
v = 0	examiner?	lospital:npatient 2 EF	VOutpatient 3□ D	OA Othe		Death Check only		er (Specify	r)
After After fune		28a. Date of Injury (Month, Day Year)  28b. Time of North Injury  28c. Injury at Work?  1  Yes 2  No					how injury occurre		·
frer frer in by		28e. Place of Injury - At hom- building, etc. (Specify)	e, farm, street, facto	ry, office		28f. Location City or To	(Street and Numbe own, State)	er or Rura	l Route Number,
within 24 hours a To the Funeral IC completely filled Medical Ce	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin one)	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death occurred n and/or investigatio	d at the time n, in my op	e, date and p inion, death o	lace, and due to the occurred at the time	e cause(s) and mai a, date and place, a	nner as st and due to	ated. the cause(s)
within To the complete Me			25	c. License	number		29d. Date signed		
4	30. Name and address of person who co		3a) (Type, Print)	D372			6 ~		06
State	31. Date filed (Month, Day, Year)	1. D. 7601 OSL 32. Registrar's Signatur 2008	ER DRIV	E TO	WSON,	MARYLA	ND 2120	4	

			1 - For State Registrar	State of	Maryland /		artmen rtificat			ınd M		giene	106	17711
			1. Decedent's Name (First, Middle, La	,							2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physici /Medic		Frances	Ernesti	ne Hanes	5					June		006	7:30 AM
	Examin		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location of	f Death		Balt	ty of Death	е
i in		4	Ivy Hall Nur: 5. Social Security Number 6.5			inthone of	If Under		lle R			h.	0.81-4	1
П	Funeral Director			1  M 2	. Age (In yrs. last bi	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day May13,	v, Year)	Cour	place (State or Foreign ptry) th Carolin
*			Usual Residence of Decedent							!'	may 15,	1741	1101	cir carorii.
	ryland		10a. State 10b. County		10c. City, Tov								1	0d. Inside City Limits
	86-1	cto	MD Balt	imore	I N	11 d	dle 1	Rive	r					1 ☐ Yes 2 No
	vith th	Director	10e. Street and Number	a			10f. Zip		•			10g. Citizen o	f What Cour	ntry?
	within 72 hours after death with the Maryland ene. then "natural", or itame 23a or 28e-f ehow fra Modical Exeminal must be notified at	era	6 Venturi Roa		ent Ever in U.S.	12	Was Doses	212		in 2 /Cnn	aifu Van ar Na	USA	ace - Americ	an Indian
	ter de	Funerai	11. Marital Status  1X Never Married 2 Married	Amed Force	es?	13.	If Yes, spec	ent of His	n, Mexican,	Puerto	cify Yes or No- Rican, etc.)	BI	ace - Amendack, White,	
980	ursat	þ	3 ☐Widowed 4 ☐Divorced	If Yes, Give Year or Dat			1 🗆 Yes	2XNo	Specify:			Spec	ity: Wh	ite
Ö 2	72 ho	Completed	15. Decedent's E (Specify only highest gr		16a	a. Dece	dent's Usua	al Occupa	ition uring most	of working	10	16b. Kind of	Business/In	dustry
7	ithin ne.	npie	Elementary/Secondary (0·12)	College (1-4		life.	lespe	se retired)	)	OF WOTEN	,g	Depar	tmen	t Store
2	lled w fygier her th	S	17. Father's Name (First, Middle, Las		yrs					da Niama	(Fine Adams)	14-id C		
anc	d be find he of	Be	Paul D. Hane								(First, Middle,			
Ž	hould d Me mark matic	2	19a. Informant's Name/Relationship		191	h Mailir	ng Address	(Street a			S M.			Codol
Maryland 21215-0036	uth an 27 is r treu		Paula Sudbroo				•	•			Abing			0000)
timore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "natural; or itame 23a or 28e-1 ehow eny injury or other treumatic event, the Madical Examinar must be notified at once.		20a. Method of Disposition	·····	20b. Place o	of Disno	estion (Nan	na of		D	ato	20a Location	City or To	own, State
Ë	Page lent o nt: if ry or		1   Burial 2 □ Cremation 3   4 □ Donation 5 □ Other (Speci		ate Hõll	Ϋ́F	ïiII	Cem	eter:	y 6,	6/06	Balti	more	MD
Balti	pertr ports y inju		21. Signature of Funeral Service Lice	nsee	1.1	22	2. Name an	d Addres	s of Facility	30	0 MAce	Ave	Balt	O MD
m	88 5 8	1	Riter	1 (0	mull	4	Coni	nell	y Fu					21221
ĸ,			23a. Part1. Enter the disease, or con shock, or heart failure. List only	olications that cau	used the death. De	ot ent								Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition	, I	ochem	ic	Co				5-pal			Onset and Death
391	/Medical Examiner		resulting in death)	Due to (or	r as a consequence	of):				1				
ı	Lxammer	_	Sequentially list conditions,	b		-0								
	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	r as a consequence	01):								
_	xecul al-trar	хап	that initiated events resulting in death) Last	c Due to (or	r as a consequence	of):								
8760	cate be executed oblysician and the burial-transit	dicat E	(	d										
٥	ifficate g phys as the	edic	<u> </u>	· ·										
Box	The law requires thet the death certific lines been signed by the ettending plage 2 should be detached for use as it	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy h 2 Fetal death	h 3[	∃Ectopic pr	ognanov				23d. D	ate of delive	nry
о. О.	deat	sicie	in the past 12 months? 1 Yes 2 No		nt at time of death		Other (sp					N	fonth	Day Year
<u>Ч</u>	of the	Phy	9 Unknown											
ś	res th	ρ	Part II. Other significant conditions	contributing to dea			nderlying ci Www.		n in Part I. Lidh	ر ل با				ne cause of death?
Ö	w require been sign should b	eted	6 0	10 . (0	22	N			7	Jar	-	es 2 No	3 Prob	ably 4 ⊕Unknown
ခိုင	e faw has t	Completed	Colon (	gun Ce	л				·- <u>-</u>		24a. Was a autop perfor	sv	prior to cor	psy findings available mpletion of cause ot
a												2 1 No	death? 1 ☐ Yes	211NO
Ħ	sicier certif irecto	Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:				. Othe			Check only or			
Division of Vital Records,		. To	27. Manner of Death	28a. Date of	Injury 28b.	utpatien Time of		8c. Injury Work	4 TYUI		ne 5 🗆 Resid			1)
<u>o</u>	nding F ath. r: After e funera	tiol	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Day Year)	Injury	М		? ′es 2.∐N	lo				
<u>N</u>	or Attendation of Att	itic	3 ☐ Suicide 6 ☐ Could not be determined	286. Place o	f Injury - At home, fa	arm, str	eet, factory	, office		2	8f. Location (S City or Tow		nber or Rura	l Route Number,
	s after ei Dire ed in by	Certification:	,	Danding	, etc. (Specify)						City of Yow	n, State)		
	To the Hospitel or Attenwithin 24 hours after deati To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical Exa	nysician: To the b	est of my knowledg is of examination ar	e, death	occurred vestigation	at the time	e, date and	f place, a	nd due to the o	ause(s) and n	nanner as st	ated.
	To the H within 24 To the Fi complete	Medi	one)	and manne	r stated.					-300110				
	To with	_	29b. Signature and title of certifier	- Alt				License		15		29d. Date sign		
•	0		11/1	1002										2006
	0		30. Name and address of person who 70 91. BAS 7	ERN	BLUD	(Type,	BA	VT11	MOF	e p	N	1.D-	212	2-1
	Sta Registr		31. Date filed (Month, Day, Year)	006	gistrar's Signature	A	poets	,						

State of Maryland / Department of Health and Mental Hygien ? [] [] 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Doris R. HArt June 3 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Ivy Hall Nursing Center Middle River If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. July 20, 1920 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 K 85 214-26-8746 Yrs. PA Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examinant must be notified at 10d. Inside City Limits MD Director Baltimore 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4824 East Hoffman Street 21205 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry John Hospital Elementary/Secondary (0-12) College (1-4or 5+) Lab Tech Hopkins permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygier
Important: If item 27 is marked other tt
any injury or other traumatic event, that 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ralph Kreidler Doris Swallenburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21220 Carole Coleburn/daughter 2116 Cockspur Road Baltimore MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Bayview Crematory 06 07 2006 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Baltimore MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave.Balto. MD <u>Connelly Funeral Home of Essex</u> 21221 23a. Part1. Enter the disease, or com-shock, or heart failure. List only cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death
Um Wizin one cause on each lin Immediate Cause (Final disease or condition resulting in death) anance **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Examiner attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. sete has been signed by the page 2 should be detached in 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 No the funeral director, 25. Was case referred to medical 26. Place of Death Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending after deeth. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier completely 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Creck unity one) 29c. License number D - 38754 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) - M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN BLVD, MD-21221 MALIKA WASERM. 709. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

			For State Registrar	State of	f Marylar		artment of H			giene	06	17713
4		· A	1. Decedent's Name (First, Middle	, Last)					2. Date of De	ath	V	3. Time of Death
F	Physici /Medic		Leonard	Richa	rd	Но	leves		5-30-	2006	Year	11:00P M
	Examin		4a. Facility Name (If not institution	, give street and nur	nber)		4b. City, Town, or	Location of Dea		4c. County	of Death	
il de la company	nation of the	87	205 Homewood Ro				Linth		,		Aru	ndel
	Funeral		5. Social Security Number	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	Hours Mir	. (Month, Da	ıy, Year)	Cou	
	Director		146-16-2883 Usual Residence of Decedent		83				11-15-	1922	N.	J
	yland iow		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation			-		10d. Inside City Limits
	Mar Mar	ţ	MD Anne	Arundel	L	inthic	um					1 ☐ Yes 2 ☑ No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cou	ntry?
	23a		205 Homewood R	oad			21090			U.S.A	<i>A</i> .	
	teme	Funerai	11. Marital Status	12. Was Dece Armed Fo	rces?		Vas Decedent of His Yes, specify Cubar	spanic Origin? ( n, Mexican, Pue	Specify Yes or No rto Rican, etc.)		ce - Americk, White,	can Indian, etc.
36	2 should be filed within 72 hours after death with the Maryland and Menthylene. and Menthylene. Is marked other than "natural; or iteme 23a or 28a-f show is marked other than "natural; or iteme 23a or 28a-f show eumatic event, the Madical Exam, per must be notified at	by F	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1⊠Yes If Yes, Giv Year or Da	е		☐ Yes 2⊠ No	Specify:		Specif	y: V	white
Ö P	stural		15. Decedent		1103.	16a. Deced	lent's Usual Occupa	tion		16b. Kind of B	usinass/in	dustry
<u>7</u>	nn 72	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed)	405 5 1	(Give	kind of work done d OO NOT use retired)	urina most of w	orking	100.11.10.01.0	0011000111	ioustry
217	d with	mo	Elementary/Secondary (0-12)	College (1	-401 3+)	Brancl	n Manager			Employm	nent .	Agency
pu	al Hy l othe	Be C	17. Father's Name (First, Middle,	ŕ				18. Mother's Na	ame (First, Middle,			
<u> a</u>	should be filed wand Mental Hygie marked other to	2	Leon Francis H	oleves				Marga	ret Mikus	5		
Maryland 21215-0036			19a. Informant's Name/Relations	nip (Type, Print)			g Address (Street a					Code)
	and leeith m 27 her tr		Mrs. Gloria Holo	eves / wif			Homewood	d Road;				
altimore,	Pages 1 nent of H int: If its iry or ot		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation	3 ☐Removal from S	1 ,	emetery, cren	sition (Name of natory or other place	)	Date	20c. Location	City or To	own, State
Ē	t. Pa rtmen rtant: rjury	. 2	4 Donation 5 Other (S)		Mar		Veterans					
Ba	permit. Departr Importu any inju		21. Signature of Funeral Service I	licensee	/		Name and Address					
			23a. Part1. Enter the disease, or	complications that co			Second A				2106	Approximate
			shock, or heart failure. List	only one cause on e	ach line.	in. Do not ont	or the mode or dying	, such as cardi	ic or respiratory ar	11631,		Interval Between Onset and Death
2	Physician /Medical		disease or condition resulting in death)	a. 194	or as a conseq	2, m	- 1216.	IBLT	1011			1HR
	Examiner						OD TIC	CAR	O O VA	5/11/0	m	Dayar
2		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (	or as a conseq	uence of):	MISMA	3 E	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	) CUCI		20425
K	acute and trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c								
8760,	i be executed sicien and burial-transit	Ã	resulting in death) cast	Due to (	or as a conseq	uence of);						
8	physic the b	dical		d								
9 ×	death certificate be executed e attending physicien and id for use as the burial-transit	Physician/Me	IF FEMALE:	23c. If yes, out	come of preons	ancy						
Box	atten for u	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bi	rth 2 ☐ Feta ant at time of d	I death 3	Ectopic pregnancy Other (specify)				te of delive inth	ery Day Year
		isic	1 ∐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno		oalli J	Other (specify)					
<u> </u>	faw requires that the as been signed by th 2 should be detache		Part II. Other significant condition	ns contributing to de	ath but not res	ulting in the ur	derlying cause give	n in Part I.	23e. Did to	obacco use cont	ribute to th	he cause of death?
Records,	n sign	d by							101	res 2 □ No	3 Prot	pably 4 Minknown
Ö	s been s shoul	Completed							24a. Was	an 24b.	Were auto	psy findings available
1	9 - 6	E O							autop perfo	rmed?	prior to co death?	mpletion of cause of
Vıtai	ien: Th rtificate stor. pag	Φ	25. Was case referred to medical	-0				26 Place of De	1 ☐ Yes eath (Check only o	7.	I □ Yes	2□ No
	ysic s ce direc	To B	examiner?	Hospital: 1 🗆 Ir	patient 2	ER/Outpatient			Home 5 Resid		er (Specif	iv)
Division of	ng Ph ter th		27. Manner of Death  1. Natural 5 ☐ Pending	28a. Date o	f Injury h, Day Year)	28b. Time of Injury	28c. Injury Work	at		now intury occur		,,
0	ttending death. stor: Afte / the fun	atic	2 ☐ Accident investig	ation		1		es 2 □ No				
Ë	after dans din by I	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 256. Place	of Injury - At he ig, etc. (Specif	ome, farm, stre y)	eet, factory, office		28f. Location (S City or Tow	Street and Numb vn, State)	er or Rura	I Route Number.
۵	spital cours af			W =								
	To the Hospital within 24 hours a To the Funaral completely filled	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical I	g Physicien: To the Exeminer: On the ba and mann	sis of examina	wledge, death tion and/or inv	occurred at the time estigation, in my op-	e, date and place inion, death occ	e, and due to the curred at the time,	cause(s) and ma date and place,	inner as st and due to	tated. the cause(s)
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier		or stated.		29c. License	number		29d. Date signed	d (Month	Day Year)
	لا ≒ ∓ م		Ale It	ion			_		38 5	_	(	2001
	./		30. Name and address of person	who completed cause	of death (Item	n 23a) (Tvna i	Print)				1	
	b		JUITAL CH	A11=n	( ~ 6	). (	18 CAT	PA	בוכתה וי	an		1717 (U)
	Sta	te	31. Date filed (Month, Day, Year)	32.	rar's Signa	iture	- 40	<u> </u>	-11077		50	2100
	Registr	ar	JUN 0 6	2006	alues 1	OF SO	and I				-	76

			1 - State of Maryland / Dep	eartment of Health a ertificate of Death	and Ment		ene2 ()	06	17716			
	Physici	an	1. Decedent's Name (First, Middle, Last)			ate of Death onth	Day	Year	3. Time of Death			
	/Medic Examin	al	Thomas J. Harden, IV  4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of	of Death	1/2		006	10:45AM			
	LAGIIII	ici	Mariner Healthcare	Catonsville				Ltimo	re			
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 64 Yrs.	If Under 1 Year   If Under 2   Months   Days   Hours	Min. (N	ate of Birth fonth, Day, Y	Day, Year) Country)					
	put		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or I	Ocation	10	123/17	71		Od. Inside City Limits			
	a-f sho	ctor	MD NT/A									
	3a or 28	I Dire	10e. Street and Number 205 Cresswell Road	10f. Zip Code 21225		10g		What Coun	itry?			
920	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or items 23a or 28a-f show many injury or other traumatic event, it a Madical Examinar traut by mulling at once.	by Funeral Director	11. Marital Status  1 Never Married Married Married Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  12. Was Decedent Ever in U.S. Armed Forces?  12. Was Decedent Ever in U.S. Armed Forces?  12. Was Decedent Ever in U.S. Armed Forces?  12. Was Decedent Ever in U.S. Armed Forces?  12. Was Decedent Ever in U.S. Armed Forces?  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent Ever in U.S. Armed Forces?  14. Yes Give Yes 1962 - U.S. Armed Forces?  14. Yes Give Yes 1962 - U.S. Armed Forces?  15. Yes 2 No 1962 - U.S. Armed Forces?  15. Yes 3 No 1962 - U.S. Armed Forces?	Was Decedent of Hispanic Origif Yes, specify Cuban, Mexican, 1 ☐ Yes 2 No Specify:	gin? (Specify Y , Puerto Rican	es or No- etc.)		e - Americ ck, White, Wh				
Baltimore, Maryland 21215-0036	in 72 ho n "netu	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation a kind of work done during most DO NOT use retired)	of working	16	b. Kind of Bu	usiness/Ind	dustry			
212	ed with ygiene ner tha			Supervisor/Cash				Air	port			
land	uld be fil fental H rkad ott tic evan	To Be	17. Father's Name (First, Middle, Last) Thomas J. Harden, III		r's Name <i>(Firs</i> i Lce E. I			19)				
lary	2 shou and N Is mai	_	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
ē, r	1 and Health tam 27 other tr		20a. Method of Disposition 20b. Place of Disp	5 Cresswell Rd.	Baltin	-	MD 21 c. Location -	. 225 City or To	wn. State			
<u>m</u>	Pages nent of ant: If i ury or		`4 □ Donation 5 □ Other (Specify) Loudon Po	ark Cemetery 6	5/3/200	6 B	altimo	ore, I	MD			
Balt	permit. Departifimport		21. Signature of Funeral Service Licensee M01442	2. Name and Address of Facility 328 Sulphur Spr	y Ambros ing Rd	se Fun	eral H utus,	lome,	Inc.			
I,			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final									
	Fnysician /Medical		disease or condition resulting in death)  Due to (or as a consequence of):									
	Examiner	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):									
	cuted nd transit	Examiner	cause. Enter Underlying Cause. Cliserse of thing that initiated events  c									
8760,	icate be executed physician and s the burial-transit	dical Ex	resulting in death) Last Due to (or as a consequence of):									
9	ntificate	Medic	d.									
O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me		☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery  Month Day Yea			•			
Records, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the		Did tobacco use contribute to the cause of death?  1 Probably 4 Unknown							
		Completed			_	la. Was an autopsy performed	1? a	rior to con leath?	osy findings available inpletion of cause of			
Vita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 FP/Outoatie	0.4	of Death (Chec				THE RESERVE THE			
Division of	ding Phys h. After this funeral di	on: To	1	IN SELECT	sing Home 5	Besidence			)			
Sio	I or Attandin after death. Director: Aff I in by the fur	icatl	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 N		cation /Stron	t and Number	v or Gural	Route Number.			
<u>&gt;</u>	ital or At	Certification:	4 Homicide determined building, etc. (Specify)	est, factory, office		ty or Town, S		ii (ii riulai	Hodie Number,			
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funerel Director: After this certifical completely filled in by the funeral director,	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal call Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and westigation, in my opinion, death	f place, and du h occurred at th	e to the caus ne time, date	e(s) and mar and place, a	nner as sta ind due to	ited. the cause(s)			
,	To the To the comp	ž	29b. Signature and title of certifier	29c. License number	765	29d.	Date signed					
ı l	Dtl	1	The state of the s	170061	105	M+	AY 3		2006			
1	7		FOFNEZEN QUALNOO MD 3350 WILL	ENS AVE #3	07 BA	LTIM	one n	00 2	1228			
	Sta Registra		31. Date filed (Month, Day, Year)  JUN 0 6 2006  32. Pigistrar's Signature	books								

			Tograda	artment of Health and M rtificate of Death	Reg. No	2000 11111	
	Physicia		1. Decedent's Name (First, Middle, Last)  Jane D. Hatcher		2. Date of Death	3. Time of Death 10:50a M	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Friends Nursing Center	4b. City, Town, or Location of Death Sandy Spring	4c	County of Death Montgomery	
F6:	Funeral Director	7.8)	5. Social Security Number  163-01-2164  6. Sex 1	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth	9. Birthplace (State or Foreign If 1111)	
	rland ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Lo.	ocation		10d. Inside City Limits	
	he Man 28a-f sh ctified	ector	MD Montgomery Sandy Sp	pring   10f. Zip Code	10g Ci	1 ☐ Yes 孝子No itizen of What Country?	
	Maryland nd 2 should be file aith and Mental Hy 27 is marked oth r traumetic event	al Dir	17340 Quaker Lane	20860		USA	
036	urs after dea al', or items Examiner m	þ	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☼ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White	
21215-0036	within 72 ho lene. • than "natur The Madical	Completed	(Specify only highest grade completed) (Give life.)  Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of worki DO NOT use retired) SINESS	ing	(ind of Business/Industry)  dvertising	
	uld be filed Aental Hygi rked other tic event,	To Be C	17. Father's Name (First, Middle, Last) Malcolm Paul Doud		e (First, Middle, Maider ise Willia	·	
Baltimore, Maryland 2: permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: if tiem 27 is marked other any injury or other traumetic event. It gares		19a. Informant's Name/Relationship (Type, Print)  David Hines/son  19b. Mailir 2853	ng Address (Street and Number or Rura Fairway Homes Way	Glen Alle	or Town, State, Zip Code) n VA 23059		
imore,	Pages 1 and of He ant: If item		20a. Method of Disposition 1 □ Burial 2 XCremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify)	psition (Name of Record Creffill Cory 06-0	Date 20c. L 5-2006 B	ocation - City or Town, State eltsville, MD	
21. Signature of Pyperal Service Licenses M00382 Rapp Funeral & Cremation Service Rapp Funeral & Cremation MD 209:							
3			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a	er the mode of dying, such as cardiac of	or respiratory arrest,	Approximate Interval Between Onset and Death	
50,	Medical Examiner  hysician and the priial-transit	I Examiner	resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	Diaheles of Antey:	Oise a	2	
68760,	tificate b g physic as the b	ledical	a Condiopi	uncorcorg	Compra	me	
.O. Box	the death certifica / the attending pt ched for use as t	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year	
ecords, P.	The law requires that the de tite has been signed by the r bage 2 should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to the cause of death?	
$\mathbf{\alpha}$	The lavate has	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No	
f Vital	Physician: Th r this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ◯XNo  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier	Othor	n (Check only one) me 5 ☐ Residence	6 ☐Other (Specify)	
ion of	ding n. Altei fune		27. Manner of Death  1XXNatural 5 Pending (Month, Day Year) 28b. Time of Injury  2 Accident investigation		28d. Describe how inju		
Division	tel or Attenders after death	Cer lification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stream building, etc. (Specify)	reet, factory, office	28f. Location (Street as City or Town, State	nd Number or Rural Route Number, e)	
	To the Hospitel or Attenwithin 24 hours after deating to the Funerel Director: completely filled in by the	edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, deat	nvestigation, in my opinion, death occurr	red at the time, date an	d place, and due to the cause(s)	
	To To COURT	Z	29b. Signature and vite of certifier  Some Meil mo	29c. License number 046584	t in	ate signed (Month, Day, Year)	
1	2		30. Name in laddress of person who completed cause of death (Item 23a) (Type, John I McNeil 13975 Connecticut Ave	e Silver Spring MD	20906		
Q.	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 33 Registrar's Signature	note)			

			1 - For State Registrar	State of	f Marylar				lealth a Death		fental Hy	gier Reg. N	201	16	1771	8
			1. Decedent's Name (First, Middle, L	ast)							2. Date of D	eath			3. Time of Death	-
	Physici /Medic		Marie A. Haug	ht							June	1,	2006	Year	2:15p	М
	Examir		4a. Facility Name (If not institution, gi						Location of	of Death		4	c. County o	f Death		_
			Genesis- Heri					ndall			,		Balti	mor	e Co.	
	Funeral	r	· ·	Sex 1 □ M 2 🕱 F	7. Age (In yrs.	last birthday) Yrs.	If Unda Months	Pr 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D May 2	rth a <u>v</u> , Ye <u>a</u>	(1)	Cou	place (State or Forei	<i>ig</i> n
1174	Director	ļ	215-07-2228 Usual Residence of Decedent		91	113.					May 2	/,1	915	Mar	yland	
	yland		10a. State 10b. County			ty, Town or Lo									10d. Inside City Limi	its
	Mar Mar	ţċ	MD N/	A	Ва	ltimo	re								1 <b>⊠</b> Yes 2 □ N	٧o
	or 28	lrec	10e. Street and Number				10f. Z	p Code				10g. C	Citizen of W	hat Cou	ntry?	_
	23a	aic	6902 Conley St	reet			2	21224	4			U	JSA			
21215-0036	n 72 hours after death with the Maryland "naturel", or Itema 23a or 28a-f ahow adical Examinar must be reditied at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married 3 ☎ Widowed 4 □ Divorced	12. Was Dece Armed For 1 Tes If Yes, Giv Year or Da	ces? 2 <b>K</b> No e		Was Dec If Yes, sp 1  Yes		spanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)	0-		, White,		
2-0	72 ho	Completed by	15. Decedent's E	ducation		16a. Dece	dent's Us	ual Occupa	ation	4 - 4 - 4		16b.	Kind of Bus	iness/în	dustry	
21		ble	(Specify only highest gi	College (1	-4or 5+)	life.	DO NOT	ork done d use retired	luring mos.	t of work	ing					
	ygien yerth	ပ္ပ	8	N/A	<u> </u>	La	bore	r				Mc	Corm	ick	¹s	
pu	be fitted H	To Be	17. Father's Name (First, Middle, Las	•							First, Middle			)		
Maryland	d Mer narke	ို	Stefan Filipia			T					nine B					
Z	d 2 st th and 7 le r traur		19a. Informant's Name/Relationship Gerald DeCosmo		-Law	7014	ng Addres	s (Street a 10 h	ind Numbe Stree	erorRura ⊃† F	Baltim	er, City	or Town, S	tate, Zip 21	2 2 / <sub>1</sub>	
	1 an Heal tem 2		20a. Method of Disposition			Place of Dispo			70100		Date		Location - C			_
Ö	ages int of t: If it		1 ⊠Burial 2 ☐ Cremation 3 [		State	cemetery, crer 1y Ro	natory or	other place		6-5-						
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 Is marked other than 'any Injury or other traumatic avant, tha Maonce.		4 □Donation 5 □Other (Spec 21. Signature of Funeral Segrice Lice		110				1				dalk			_
B	Depa Impo any Ir		Melle	-	-	1	201	Dunc	1 <sub>2</sub> 1 <sub>k</sub>	'Kac	zorow	ski	Fun	era	$1_{2}$ Home, I	? [
	3		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that ca	used the deat	th. Do not ent	er the mo	de of dying	Address of Facility Kaczorowski Funeral Home, undalk Ave. Baltimore, MD 21222  If dying, such as cardiac or respiratory arrest,  Approximate Interval Between Onset and Death	_						
· ·	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  a. CONGESTIVE HEART FAILUS ID Due to (or as a consequence of):  Sequentially list conditions							URE HYCA	RL	)/B		Onset and Death	_		
16	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (	or as a consequence	juence of):	101	·N								
o,	ficate be executed physician and is the burial-transit	Exa	resulting in death) Last		POTH or as a conseq			• /								
8760,	ysicia	dicai		d. DE	PRES	SIDA										
9	ng ph as th	(0)	IF FEMALE:													
.O. Box	The law requires that the death certific ale has been signed by the attending p page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown		nth 2 ☐ Feta ant at time of d	death 3	Ectopic p Other (s	Ectopic pregnancy Other (specify)				23d. Date of delivery Month Day		*		
٦,	res that igned b	by PI	Part II. Other significant conditions	contributing to de	ath but not res	ulting in the ur	nderlying	cause give	n in Part I.		23e. Did t	obacco	use contrib	ute to th	ne cause of death?	-
rds	quire: in sig uld bi	d be					_				1 🗆	Yes :	2 □ No 3	☐ Prob	ably 4 Dunknow	m
Records,	aw requir s been si 2 should	Completed									24a. Was	an	24b. W	ere auto	psy findings availab	le
æ	The lavate has page 2:	Eo										rmed?	pri de	or to cor ath?	npletion of cause of	İ
Vital	iclan: The certificate rector, pag	Bec	25. Was case referred to medical						26. Place	of Death	↑ Yes	2 N	10	Yes	25 No	
<b>o</b>	d is	To	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 🗆 Ir	patient 2 🗆	ER/Outpatien	t 3 🗆 D	Othe	_ /		ne 5 Resi		6 □Other	(Specifi	/)	
0			27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date o (Month	f Injury n, <i>Day Year</i> )	28b. Time of Injury		28c. Injury Work			28d. Describe				<u></u>	-
Division	Attending it death.  ector: After by the fune	Certification:	2 Accident investigation	n			М		'es 2 □ l	No						
Ξ	or Attendate death Director: in by the	T T	3 ☐ Suicide 6 ☐ Could not to determined	28e. Place	of Injury - At ho g, etc. <i>(Specif</i>	ome, farm, str	eet, factor	y, office			28f. Location ( City or To	Street a	ind Number te)	or Rura	l Route Number,	_
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by															
	Hosp 24 ho Fune Fune	Medical	29a. Certifier 1 √ Certifying P (Check only one) 2 ☐ Medical Exa	hysician: To the miner: On the ba	sis of examina	wledge, death	occurred estigation	at the time	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(:	s) and mann	ner as st	ated. the cause(s)	
	ithin 2 of the	Mec	29b. Signature and title of certifier	and mann	er stated.			c. License								
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	1.		30 Hame and address of pages	completed cause	ELL.	MD	Drigs\	0	4)	188		6	1//	56		
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Va.	a.⊲ w Sta	te	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa		-	1 10		0	unqu	216	14/	, _	1	
	Registr	-	ILIN 0 6 2006	Flour.	1	angeli										

06-03810

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene James E. Hill, 3rd 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month 0712 hrs **Medical Examiner** James Ellwood Hill, III June 4, 2006 4c. County of Death 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore City 947 Horners Lane If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Funeral Months Days Hours Director 52 Country) MD 217-60-0893 1X M 2 1 - 30 - 1954Usual Residence of Decedent I0c. City, Town or Location 10d Inside City Limits 10a. State 10b County Yes 2 No Baltimore City or 28a-f show MD : 23a or 28a-f sho : notified at once. death with the Maryland Director 10f, Zip Code 10g Citizen of What Country 10e. Street and Number USA 21225 947 Horners Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black 11 Marital Status 12. Was Decedent Ever in U.S. nust be 1 Never Married 2 Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc Armed Forces' Yes Specify: White If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed Divorced ş 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry ges 1 and 2 should be filed within 72 hours: of Health and Mental Hygiene.
If item 27 is marked other than "natury ther traumatic event, the Medical Exami 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled Disabled Baltimore, MD 21215-0036 1.0 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ida G. Parlett Be James Ellwood Hill, Jr. 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 243 Baltimore Avenue, Dundalk, MD 21222 Ida G. Hill - Mother 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a Method of Disposition Important: If it injury or other t crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Baltimore, MD 6-6-06 ent Bayview Crematory Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Bradley-Ashton Funeral Home 23a. Part I. Enter the disease, or complications that caused the death. Do not enter **Physician** failure. List only one cause on each line Between Onset and /Medical Death Atherosclerotic cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical AMENDED item#23a,PII,27,perME,g856,6/14/06 TT X UNPENDED physician the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IE EEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Month 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown letached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Chronic obstructive pulmonary disease Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a Was an 24b Were autopsy findings available autopsy prior to completion of cause of has performed? death? Yes 2 2 No this certificate 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death 25. Was case referred to medical 26.Place of Death (Check only one Be examiner? Other<sub>4</sub> Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✓ Other, Scene 1 V Yes 28a Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d Describe how injury occurred 28b. Time of Injury After 27 Manner of Death Certification 1 X Natural Yes 2 5 Pending Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 Could not be Suicide or Town, State) To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started cal (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. June 4, 2006 30. Name and address f person who come ed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201

State Registrar

Jack Titus MD 31. Date filed (Month, Day, Year,

Registrar's Signature

Deputy Chief Medical Examiner

			State of Maryland / Department of Certificate of		ental Hygier	C U U	6 1772	20
	Physicia	20	Decedent's Name (First, Middle, Last)				3. Time of De	
	/Medic		Harold Benjamin Hess			2, 200		M M
	Examin			, or Location of Death		4c. County of		
	7.1		Upper Chesapeake Medical Center Bel 7 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yea	The second secon	8. Date of Birth	Hari	Ord Birthplace (State or F	Foreign
	Funeral Director		1⊠M 2□F Yrs Months Days		(Month, Day, Yea	ar)	Country) Maryland	or orgri
	X		220-34-7048 11 88 Usual Residence of Decedent		Apr. o,	1710	-	
	nylan how		10a. State 10b. County 10c. City, Town or Location				10d. Inside City	
	Ba-1 e	Director	Maryland Harford Monkton				1 ☐ Yes 2	: Muo
	with th		10e. Street and Number 10f. Zip Code		10g.	Citizen of Wh	at Country?	
	s 23	Funeral	3115 Jarrettsville Pike 211.  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of		cify Yes or No-	USA 14. Race	American Indian,	
	ter de	'n.	Armed Forces?  1 □ Never Married 2 Married 1 □ Yes 2 ☑ No	of Hispanic Origin? (Specuban, Mexican, Puerto F	Rican, etc.)		White, etc.	
	Urs at	by	1 ☐ Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 No If Yes, Give Year or Dates:	lo Specify:		Specity:	White	
Pm	1215-0036 within 72 hours after death with the Maryland ane. then "netural", or items 23a or 28a-1 show he Marifiel Examiner roust be notified at	Completed	15. Decedent's Education 16a. Decedent's Usual Occi (Specify only highest grade completed) (Give kind of work don	cupation ne during most of workin	16b	. Kind of Busi	ness/Industry	
	N in the last	du	Elementary/Secondary (0-12) College (1-4or 5+)	ired)				
7	W Personal Property of the Personal Property o	S	12 Owner/Operat	18. Mother's Name		airy Fa	irming	
414	Maryland 21215-0036 at 2 should be filed within 72 hours aft th and Mental Hygiene. Z7 is marked other then "netural", or traumatic event, the Medical East in	Be c		- 12	lav Base			
-	Tyleshould Me Me Me Me Me Me Me Me Me Me Me Me Me	ို	Benjamin Garfield Hess  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street		- 4		ate, Zip Code)	
	Ma and 2 s alth ar 27 le		Evelyn B. Hess/Wife 3115 Jarretts	sville Pike	, Monkton	n, Mary	land 21111	L
9	Baltimore, Maryland 21215-0036 permit Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mandal Hygiene. Important: If item 27 is marked other then "netural", or items 23s or 28s-1 show any injury or other traumatic event, the Marildal Extrainer must be nutitied at once.		20a. Method of Disposition 20b. Place of Disposition (Name of	place) Dr	ate 20c	. Location - C	ity or Town, State	
6/a/06	Page Page nent o nnt: If		1		06-2006 1	Fallsto	n. Marylar	fac
d	mit mit partit porte y inju		21. Signature of Funeral Service Licensee 22. Name and Add	uneral Home	D A	LLLOU	and item lates	
0	<b>o</b> 88 E 5 8			sbury Road,		n, Mary	zland 2100	)9
9	2.		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line.	ying, such as cardiac or	r respiratory arrest,	_	Approximate Interval Betwe	
	Physician		Immediate Cause (Final disease or condition  Arrive thrus				Onset and Dec	u 3
_	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				2 1	
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I	Box eath cert attendin for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnan	лсу		23d. Date Month		25
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2	P.C	P.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause of	given in Part I	23e Did tobaco	co use contrib	ute to the cause of dea	ath?
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<u>ب</u>	Vital Record icien: The law requir certificate hes been si rector, page 2 should	Completed	Emphysera		autopsy performed	? de	ere autopsy findings ava or to completion of caus ath?	ise of
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<u>ડ</u>	g Phy er this		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury		8d. Describe how in			
7	Vision Attending r death. ector: After by the fune	atlo		☐Yes 2☐No				
ess, Harold Mobbol	Division  or Attending after death. Director: After in by the fune	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)	же 2	.81. Location (Street City or Town, St	t and Number tate)	or Rural Route Numbe	эг,
2	Dital of	Cer						
主	Hosp 4 hou Fune ely fil	edical	29a. Certifier (Check only   Medical Examiner: On the basis of examination and/or investigation, in my	time, date and place, a y opinion, death occurre	and due to the cause and at the time, date	e(s) and manr and place, an	er as stated. d due to the cause(s)	
	Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physicien: The law requires that the death certifica within 24 hours after death.  Within 24 hours after death.  Completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Med	one) and manner stated.  29b. Signature and title of certifier 29c. Lice	ense number	29d	Date signed /	Month, Dey, Year)	
	Twit oo			053568				
	100					ne Z,		_
	1.0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	par Clas	clesapo	iake	Kand	
	Sta	ate	31. Date filed (Month Day, Year) 32. Registrar's Signature	JAIC 1	arylan	et 2	1014	
	Regist		JUN 0 6 2006 Degree & Aprile					
	DHMH 17 Rev 1/2	001						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] [ ] [ 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JUNE 2, 2006 HYATT 3:03 P CAROLYN 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOWARD COUNTY GENERAL HOSPITAL COLUMBIA HOWARD II Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) 6. Sex Days 04/21/1921 Months Hours Min 1 □ M 2 🙀 F NY 85 071-12-5274 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 🔀 No MD BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 1866 AUTUMN FOREST LANE 21209 . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 💢 No Specify: Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0·12) **EDUCATION** TEACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) **FRANK** LEVY RUTH SYLVIA BERNARD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1866 AUTUMN FOREST LANE - BALTIMORE, MD 21209 JACK I. HYATT / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State HAR SINAI CEMETERY 06/04/2006 OWINGS MILLS, MD 4 □ Dogaston 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Funeral Service 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or comshock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) SEPSIS days Due to (or as a consequence of): days PNEUMONIA

**Physician** /Medical Examiner

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Examiner

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Certification:

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**Physician** 

/Medical

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Director

r than "natural", or iteme 23s or 28s-f show the Madical Examiner must be nutified at

filed within 72 hours after Hygiene.

permit. Pages 1 and 2 should be filed of Deperment of Health and Menial Hygic Important: if Item 27 is marked other any injury or other treumatic event.

Baltimore, Maryland 21215-0036

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ed by the attending physician and detached for use as the burial-transit

After this certificate has been si funeral director, page 2 should cumpletely filled in by the funeral efter death.

Division of Vital Records, P.O. Box 68760

the Hospitel or Attending Physician:

within 24 hours

sequentially list conditions, any, leading to infinediate ause. Enter Underlying Cause (Disease or injury that initiated events esulting in death) Last	c. OSTRI Due to (or as a consequent	DIUM	DIFFICI RTERY			
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⅣNo 9 □ Unknown	23c. If yes, outcome of pregnance 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3 Ectopic pr			23d. Date ol delivery Month Day Year	
Part II. Other significant conditions					o use contribute to the cause of death?	
EN	DSTAGE	RENA	DISEA	SE 1□Yes	2 No 3 Probably   ☐ Probably	
				24a. Was an autopsy performed?		
25. Was case referred to medical examiner?  1  Yes 2	Hospital: Inpatient 2 EF	VOutpatient 3□ DC	Othor	ath (Check only one)  Home 5 - Residence	6 □Other (Specify)	_
27. Manner of Death  Natural 5 Pending 2 Accident investigati	28a. Date of Injury 28 (Month, Day Year)		Bc. Injury at Work? 1 Yes 2 No	28d. Describe how in		_
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		e, larm, street, lactory	, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)	
	Physician: To the best of my knowled aminer: On the basis of examination and manner stated.					
29b. Signature and title of certifier		290	. License number	29d. D	Date signed (Month, Day, Year)	
Spr J	LEMD	D	005315	0 10	INE 3rd 2006	2
30. Name and address of person wh	completed cause of death (Item 2	3a) (Type, Print)		SUI	TEILO MD	
Shakunma	ale gupra	1650 5	ANTIHGO	KD CO	CUMPIA 4045	

State Registrar

JUN 0 6 2006 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature Eleve It Sparke

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Howard D. Isennock Sr. May 31, 2006 2:40 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8/01/1925 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 12M 2□F Days Hours Min 197-18-4853 80 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show 1 ☐ Yes 2 ☐ No MD Baltimore Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö the Madical Examiner count be 3200 E. Joppa Rd. 238 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: iteme! 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 5 Maryland 21215-0036 1 Yes 2 No Specify: þ 3 ■ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) other than College (1-4or 5+) Baltimore County Police Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Deperment of Health and Mental Hy Important: if item 27 is marked oth any lighty or other traumatic event once. Be Morris E. Isennock unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott Isennock - Son 3200 E. Joppa Rd. Baltimore, MD 21234 Baltimore. e 3, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition competency crematory or other place)
Dulaney Valley
Memorial Gardens June 1 ■ Burial 2 □ Cremation 3 □ Removal from State Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Juneral Service Licensee 22. Name and Address of Facility 8800 Harford Rd. Parkville, MD 21234 Evans Fueral Chapel 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** persons disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury heart fuilme Examiner or Attending Physicisn: The law requires that the death certificate be executed that initiated events resulting in death) Last Box 68760. Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Division of Vital Records, P.O. 9 Unknown s been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part It Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificete 1 Yes ₹No : After this certifice funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 1 No 2 ER/Outpatient 3 DOA Inpatient 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Natural 2 Aceident death. 1 ☐ Yes 2 ☐ No iours after death.

nerei Director: A
filled in by the fu investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerei 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signat ₩gistrar's Signature State Registrar

DHMH 17 Rev 1/2001

06-03597 Karen S. Johnson

**Medical Examiner** 

**Funeral** 

Director

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Division of Vital Records,

To the Hospital or Attending Physician:

MD

17. Father's Name (First, Middle, Last)

20a Method of Disposition

19a, Informant's Name/Relationship (Type, Print ) Andrea Mayfield/ Daughter

Burial 2 X Cremation 3

Physician/

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No Registra Decedent's Name (First, Middle,Last) 2. Date of Death Month Day May 27, 2006 1643 hrs Karen S. Johnson 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Bon Secours Hospital If Under 24Hrs 8 Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5 Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year oreign Months Hours Country) MD 212-84-8339 2 X F M 05-03-1967 39 Usual Residence of Deceden 10d Inside City Limits 10c City, Town or Location 10a State 10b County 1 X Yes 2 No Baltimore NA 10f. Zip Code 10g Citizen of What Country? 10e. Street and Number 21216 TISA 2400 Winchester Street 13 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14 Race - American Indian, Black White, etc. Armed Forces' 1 X Never Married 2 Married 2 X No Yes f Yes, Give Year Yes 2X No specify **Black** Widowed Divorced 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12)

Homemaker

2400 Winchester Street Baltimore, MD

Baltimore, MD 21215-0036 Pages 1 and 2 should be filed within 7 nent of Health and Mental Hygiene 11: If item 27 is marked other than or other permit Pages Department of Important: Metro Crematory Donation 5 Other Specify: Signature of Funeral Service Licenses 22 Name and Address of Facility Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line /Medical Acquired Immunodeficiency Syndrome AIDS) Immediate Cause (Final disease Examiner

un!mown

Removal from State

Wylie Funeral Home P.A. 638 N. Gilmor St. Baltimore, MD 21217 Approximate Interval Between Onset and

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

06-05-06

Julia Harding

Domestic

20c. Location - City or Town, State

Year

Day

May 28, 2006

Catonsville, MD

or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last AMENDED item#23a,27,perME,g857,7/10/06 TI

XUNPENDED 23c. If yes, outcome of pregnancy IF FEMALE. 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Month Fetal death past 12 months?

Pregnant at time of death 5 Other (Specify) Yes 2 No 9 V Unknown Unknown

23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

20b. Place of Disposition (Name of cemetery,

crematory or other place)

1 Yes 2 No 3 Probably 4 Unknown 24b Were autopsy findings available 24a Was an autopsy performed? prior to completion of cause of death?

✓ Yes 2 ✓ Yes 26 Place of Death (Check only one) 25. Was case referred to medical Other<sub>4</sub> examiner? Hospital 1 Inpatient DOA 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 1 V Yes

28d Describe how injury occurred 28a Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27 Manner of Death 1 X Natural Pending Yes 2 No Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State)

Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c License numbe

2000

O.C.M.E.

pursue 30. Name and address of person who completed cause of death (Item 23a)

determined

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner

Margarita Korell MD. 3∰ Registrar's Signature

31. Date filed (Month, Day, Year) State Registrar 11IN 0 6

State of Maryland / Department of Health and Mental Hygien () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Dolores Marie Jennings Month Yeer **Physician** 00:12 MAT 31 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Jan. 11, 1950 ST. AGNES HEAUTHCAKE N/A5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months Days 1 □ M 2 1 F 217 76 3202 56 Yrs. Director Mary1and Usual Residence of Decedent filed within 72 hours efter death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or itama 23a or 28a-f ahow traumatic event, the Mudical Examinar must be notified at N/A 1K Yes 2 □ No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2606 Cole Street U.S. 21223 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Cook 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Leonard Bateman Sr. Esther Agro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum once. Leonard Bateman Jr./ Brother 1451 Old Ft. Smallwood Road Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State MD State Veteran Cem. 6/2/2006 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service License 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the wath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final ARRITHMIA **Physician** disease or condition resulting in death) - Hours /Medical Due to (or as a consequence of) Examiner INFARCTION - HOURS MYCCARDIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed anding physicien and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š PULMONARY CHYCONIC OBSTRUCTIVE DISTAGE 3 Probably 4 □Unknown Completed 1 ☐ Yes 2 ☐ No peed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death |Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 ☐ Yes 2 ☑ No Certification; To 2 ER/Outpatient 3 DOA 27. Mannerof Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred hours after death. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number. City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P18614 Chevrales, MD MAY 31, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD 21229 MAKIA C IZOSALES. 900 & CATON AVE 31. Date filed (Month, Day, Year) 32. Mustrar's Signature State Registrar

DHMH 17 Rev 1/2001

Box 68760,

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** JOHNSON 06 15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore County Towson Manor Care Nursing Home If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 5. Social Security Number **Funeral** Months Days Hours Min 1**/2**₩ 2□ F 19,1926 80 Yrs. Maryland Feb. Director 220-12-6614 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County Items 23a or 28a-f show the Medical Examiner must be notified at 1 TYes 2X No Towson Maryland Baltimore Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21286 USA 509 E. Joppa Road permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23s any injury or other traumatic event, the Wedfell Examinet mutal once. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 white 3₺ Widowed 4 Divorced WII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Police Officer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Briged Keegan Edward Johnson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21211 Baltimore, MD 3732 Tudor Arms Ave. Son Bruce Johnson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2XXX remation 3 ☐ Removal from State 6/6/2006 Catonsville, Maryland Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211 21. Signature Funeral Sa tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) heimer Pnysician /Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit Due to (or as a consequence of) /Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 DEctopic pregnancy Year Month Day 5 Other (specify) detached outing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown will 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 ☐ No 1 Yes 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of

Box 68760, Division of Vital Records, P.O. To the Hospital or Attending after death within 24 hours a To the Funeral C

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ed by PI	Part & Dther signif	icant conditions co	ontrib
Medical Certification: To Be Completed by Physiciar	Meen	/ uns	ra
ro Be C	25. Was case referexaminer?		Hos
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Certific	3 Suicide 4 Homicide	6 Could not be determined	1
edical (	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	
ž	29b. Signature and	title of certifier	

MANY

3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	./		
29a. Certifier (Check only	1 Certifying Physical Examin	cian: To the best of my knowledge, death occurred at the time, date and plater. On the basis of examination and/or investigation, in my opinion, death oc	ce, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)

(Check only one)	2 Medical Examir	ner: On the bas and manne	is of examination	on and/or investigation, in my opinion, death occurred at the tir	ne, date and place, and due to the cause(
29h. Signature and	d title of certifier	1	1.0	29c. License number	29d. Date signed (Month, Day, Year)

Charles

030433 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAY, 25, 2006 Ballimore M121204

State Registrar

32. Reg strar's Signature 6 2006

		-	For State Registrar	State of N	Maryland		artment <i>tificate</i>				ental		ene	06	17	726
			Decedent's Name (First, Middle, Las	t)							2. Date		Day	Year	3. Time o	of Death
	Physicia		John Kean							N	Montl 1ay 2			rear	7:30	D M
	/Medic Examin		4a. Fecility Name (If not institution, give	street and number	er)		4b. City,	Town, or	Location					nty of Death		
	LXUIIIII	Ğ.	Brooke Grove Reha	b & Nurs	ing		Sandy	Spi	ring				Mont	gomer	y	
	Funeral		5. Social Security Number 6. Se	ex 7.	Age (In yrs. I	ast birthday)	If Under	1 Year	If Under	24 Hrs. Min.	8. Date	of Birth		9. Birth	place (State untry)	or Foreign
	Director		577-28-7083	M 2□F	84	Yrs.	Months	Days	Hours		Nov .			Can		
	70		Usual Residence of Decedent									•••				
	ylan		10a. State 10b. County		10c. City	, Town or Lo	cation								10d. Inside (	ity Limits
	Ma-1-	Director	MD Montgon	nery	Sil	lver S	pring								1 1 1 1 1 1 1	25 140
	h the	lre	10e. Street and Number				10f. Zip	Code				10	g. Citizen o	of What Cou	untry?	
	1 wil		15115 Interlacher	Drive			209	906				U	SA			
	dea F	Funeral	11. Marital Status	12. Was Decede Armed Force		S. 13.	Was Deced	lent of Hi	spanic Or	rigin? (Spe	cify Yes	or No-		ace - Amer lack, White	ican Indian, . etc.	
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2	should be filed within 72 hours after death with the Maryland nd Mental Hygiane. marked other than "natural", or iteme 23a or 28a-f ehow marked other than "natural", or iteme 23a or 28a-f ehow imatic event, the Madical Examinar must be notified as	d by	3 Widowed 4 Divorced	Year or Date	s:			1750				-		wh:	ite	
<u>ر</u>		Completed	15. Decedent's Ed (Specify only highest gra			(Give	dent's Usua kind of wor	k done o	durina mos	st of worki	ng	1	6b. Kind of	Business/i	ndustry	unk
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<u>×</u>	should Ind Men	ပ္	Alfred Henry Kear							a Sco			~			
a	s 1 and 2 should if Heelth and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (	Type, Print)		19b. Maili	ng Address	(Street a	and Numb	er or Rura	il Route ∧	lumber,	City or Tou	vn, State, Z	ip Code)	
≥ .	and m 27		Ruth Kean/wife		1				chen						D 2090	6
ore.	of He		20a. Method of Disposition  1  Burial 2  Cremation 3	Removal from Sta	1 0	lace of Dispo emetery, crea	natory or o	ne of ther plac	e)	L	ate	2	Oc. Locatio	n - City or 1	Town, State	
Ĕ	Peges nent of int: if it ury or o		4 ADonation 5 Other (Specify						İ							
Baltimore, Maryland 21215-0036	permit. Peges Depertment of important: If it eny injury or o		21. Signature of Funeral Service Licen	Wades Di	irector	r S	Name an tate A altim	Anat	omy I	Board	655	W.	Balti	more	Street	=
			23a. Part1. Enter the disease, or com-	plications that cau	sed the death						r respirat	ory arre	st,		Approxima Interval Be	ate
			shock, or heart failure. List only Immediate Cause (Final	^			20	A	A- 1	. ^					Onset and	Death
,	Physician /Medical		disease or condition resulting in death)		as a consequ		TNE	EWI	NON	(H				-	2 6	712
	Examiner				-										6 W	EEKS
		36	Sequentially list conditions, if any, leading to immediate		PHAC as a consequence								<u> </u>	+	4 10	
	pet list	ulu u	cause. Enter Underlying Cause (Diseese or injury	CFR	EISRI	41.	INF	ADC	-						6 W	EKS
	and and	Examiner	that initiated events resulting in death) Last	C	as a consequ			1,00								
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P. O.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknow		<b>55</b>	J 011101 (Sp									
	het II	P.	Part II. Other significant conditions of	contributing to deat	h but not res	ulting in the u	inderlying c	ause give	en in Part	I.	23e	Did tob	acco use co	ontribute to	the cause of	death?
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0	need houl	Completed									040	10.5	104	h 1860-0-0-0	tonou finding	a available
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/ita	Physician: Th r this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hamilton				100		e of Death	(Check	only one	)			
<u>&gt;</u>	hysi this c	P	1 Yes 2 No	Hospital: 1 Inp		ER/Outpatie			4 10014					Other (Spec	city)	
ב	Ing P	Ö	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of (Month,	Day Year)	28b. Time o Injury		28c. Injun World			280. Des	cupe no	w injury occ	curred		
Sio	Attending r death. ector: After by the fune	cat	2 Accident investigation				М		Yes 2 □		201 1	(0)			- 10	
Division of Vital Records,	or Attendethered efter death	Certification:	3 Suicide 6 Could not b 4 Homicide determined	289. Place of	Injury - At he , etc. <i>(Specif</i>	ome, farm, st y)	reet, factory	y, office				tion (Str or Town		mber or Ru	iral Route Nu	m <i>ber</i> ,
Ω	ral Dellied															
	To the Hospital or Attending Physician: The law within 24 hours elter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier 1 X Certifying Ph (Check only 2 Medical Examone)	nysician: To the be miner: On the bas	is of examina	wledge, dea ition and/or in	th occurred ivestigation	at the tin	ne, date a pinion, de	and place, eath occurr	ed at the	o the ca time, da	use(s) and ite and plac	manner as e, and due	stated. to the cause	(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manne	r stated.		290	c License	e number			-29	d. Date sig	ned (Monti	n, Day, Year)	
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			30. Name and address of person who	1	of death (Item	n 23a) (Type	Print)	_	1.1.	1 1 A	mc 7	DAT	>	ms		
			31. Date filed (Month, Day, Year)	(54)	pietrare Sinn	4511	V >	( ,	0010	ノーー	ליזו (	700	-1-	11.1	/	
	St Regist	ate rar	JUN 0 6 20	106	gistrar's Signa	F A	are									
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State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician Elmer S. Keppler 20්රී6 31. 5:31 PM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center **Examiner** Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 F 74 July 4, 1931 Maryland Director 219-28-7559 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r than "natural", or itams 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No X Director Abingdon Md. Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21009 214 Laurentum Parkway death Funerai 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? tx☐Yes 2☐No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 🏖 ☐ No Specify: Specify: white ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry military dept -16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) State of Maryland personnel director permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If Item 27 is marked other It any injury or other traumatic avant, ILA ODG. 12 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Annabell Maude Stump James J. Keppler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 214 Laurentum Parkway, Abingdon, Md. 21009 Bernadette Keppler/wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2x Cremation 3 ☐ Removal from State Bayview Crematory 6/3/06 Baltimore, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014 man 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CORONARY ARTERY DISEASE Physician /Médical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. The law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown should t Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? has le 2 rector, page 2 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pendina Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Funeral Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 5-31-06 D 30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS KHOO, M. D. , 7601 OSLE DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 6 2006

06-03702 Raymond L. Kiser

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 17728

.,		1- For State Certificate C	of Death	Reg	. No	10 1116
Physiciar edical Examine	1	1. Decedent's Name (First, Middle,Last) Raymond Lloyd Kis	ser	2. Date of Death Month May 31, 20	Day Year 06	3. Time of Death 0607 hrs
		4a. Facility Name (if not institution, give street and number) Harbor Hospital Center	4b. City, Town, or Location of De Baltimore	ath	4c. County of Dea	th
Funeral Director		5. Social Security Number 215 64 4829 6. Sex 7. Age (In yrs. last birthday) 51 yr		May 2,	Fore	irthplace (State or eign country) Maryland
th the Maryland 23a or 28a-f show any notified at once.		Usual Residence of Decedent  10a. State	ı			10d. Inside City Limits  1 Yes 2 XNo
the Maryl a or 28a-1	DIRECTOR	10e. Street and Number 1981 Bayside Beach Road	10f. Zip Code 21122	10	g. Citizen of What Co U.S.	untry?
er death wi	by Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced of Dates:	/as Decedent of Hispanic Origin? (Yes, specify Cuban, Mexican, Pue	erto Rican, etc.)	White, etc. Specify: Wh	erican Indian, Black,
5-0036 led within 72 hours a Hygiene. other than "natura the Medical Exami	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ent's Usual Occupation (Give kind most of working life. DO NOT use .etician		16b. Kind of Business Harbor	s/Industry Hospital
ID 21215-0036 should be filed within 7 and Mental Hygiene. 77 is marked other than matic event, the Medicin	Be Con	17. Father's Name (First, Middle, Last) Paul R. Kiser	Dor	ime (First, Middle, M is Samuel		
y, MD 2121 and 2 should be fi ealth and Mental tem 27 is marked traumatic event,	2	Alice Whitaker / sister in law 1981	ng Address (Street and Number Bayside Beach	Road Pasa	adena, Mar	yland 21122
Baltimore, ME Dermit. Pages I and 2 s Department of Health an Important: If item 27 injury or other traumi		1 V Puriol 2 Cremation 3 Removal from State crematory or c	osition (Name of cemetery, other place)  dge Mem. Park	Date 5/5/2006	20c. Location - City of Elkridge,	
Baltimore permit. Pages 1 Department of Important: If injury or other		21. Signature of Funeral Service Ocensee 40	Name and Address of Facility ( Ol Ritchie Highw	way Balti	more, Mary	yland 21225
Physician /Medical £xaminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.  Immediate Cause (Final disease a. Salicylate intoxication	the mode of dying, such as cardia	ac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
	_	or condition resulting in death)  Due to (or as a consequence of):  b.  Bequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):				
	caminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
'60, ate be executed bhysician and ne burial - transit	ical Ex	d.  X UNPENDED AMENDED item#23a PTT 27	,28a-f,perME,g856,6	/28/06 TT		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Fineral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	sician/Medical	1F FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fregnant at time of death 5 (	Fetal death 3 Ectopic pre		23d. Date of delive Month	Day Year
ires that the des	2	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.			to the cause of death?
Division of Vital Records, Fat or Attending Physician: The law requires rs after death.  "In Director: After this certificate has been signled in by the funeral director, page 2 should be	Completed			24a. Was a autops perfor	n 24b. Were a prior to death?	autopsy findings available o completion of cause of
ital Rician: T	Be	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ✓ ER/Outpatie	26.Place of Death (Che		Residence 6 Oth	iet.
n of Vital Reco ding Physician: The law h. : After this certificate has	on: To	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Month, Day, Year)		28d. Describe h	ow injury occurred	
Division spital or Attenciours after death terral Director: filled in by the	Certification:	2 Accident Investigation FIEL 5/51/2005 UTIK  3 Suicide 6 X Could not be determined (Specific Lands)	A	28f. Location (S or Town, St unk		Rural Route Number, City
Division To the Hospital or Attend within 24 hours after death To the Fineral Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one)  29a Medical Examiner: On the best of my knowledge, death occurrence one)  2 Medical Examiner: On the basis of examination and/or investig	curred at the time, date and place, pation, in my opinion, death occurre	and due to the cause	e(s) and manner as st and place, and due to	arted. the cause(s)
	Mec	and manner stated.  29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (May 31, 2006)	fonth, Day, Year)
19thand		30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 111 Per	nn Street, Baltimore, MD 2	1201		
St: Regist	ate rar		arke			
DHMH 17 Rev 1/20	_	ORIGIN	AL			

			For State	State of Maryl	•	irtment of He <i>tificate of D</i> e		11100	_	17729
			Registrar  1. Decedent's Name (First, Middle, Last)		061	incate of D	2	Reg.  Date of Death		3. Time of Death
	Physici /Medic		Lula Ann Kus				J	une 1, 200	Day Year 6	5:10 A. M
	Examin		4a. Facility Name (If not institution, give s 3118 California Avenue	treet and number)		4b. City, Town, or Lo	ocation of Death		4c. County of Dea Baltimore	th
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year	f Under 24 Hrs. 8	Date of Righ	Q Rie	thplace (State or Foreign
В	Director		213 10 0103	M 2DAF 83	Yrs.	Months Days	Hours Min.	Month, Day, Ye pril 27, 1	923 Mai	ryland
	land ow		Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or Lo	cation				10d. Inside City Limits
	ith the Marylan or 28a-f show	ctor	Maryland Baltimore		Parkville					1 ☐ Yes 2 📉 No
	or 28	Direc	10e. Street and Number			10f. Zip Code			Citizen of What C	ountry?
	eath v	Funeral Director	3118 California Avenue	2. Was Decedent Ever	in U.S. 13 V	21234	anic Origin? (Speci		USA 14. Race - Ami	erican Indian.
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene.  If Item 27 is marked other than "netural", or Items 23a or 28a-f show or other treumatic event, the Medical Examinar ment be muffled at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Vas Decedent of Hisp f Yes, specify Cuban, □ Yes 2 No	Mexican, Puerto Ric Specify:	can, etc.)	Specify: Wh	te, etc.
5-0	72 hc	eted	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	lent's Usual Occupation kind of work done dur OO NOT use retired)	on ring most of working	16b	. Kind of Business	/Industry
121	filed within Hygiene. other than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Homemak				wn Home	
	be filed ital Hygid of other event, II	BeC	17. Father's Name (First, Middle, Last)			11	8. Mother's Name (i	First, Middle, Maid		
Maryland	should be nd Mental marked o	일	James A. Tracey Sr.				Helen E. C			
Mar	d 2 shoth and the and treums		19a. Informant's Name/Relationship (Typ. Charles L. Kus, Jr./Sor			g Address (Street and Wersby Road		Route Number, Cit <b>/lan</b> d 2108		Zip Code)
re,	s 1 and of Health Item 27 other tr		20a. Method of Disposition	20	Ob. Place of Dispo		Dat		Location - City or	Town, State
imo	Page ment c ant: If ury or		1		Gardens Of	Faith	6/5/200		Baltimore	Maryland
Baltimore,	permit. Pages 1 an Depertment of Heal Important: If Nem 2 any Injury or other <u>once</u> .		21. Signature of Funeral Service License	· Christina L C-Hitton	. Hilton 22	Name and Address Leonard J. Ru	of Facility 50 uck, Inc. Bo	305 Harford Altimore Ma	d Road aryland 21	1214
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	e cause on each line.		1				Approximate Interval Between Inset and Death
}	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			breas	TCANC	212		59
н	Examiner			Due to (or as a cor	isequence oi).					/
. 1	Do is	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a cor	nsequence of):					
٧	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):					
68760,	ysiciar e buri	edical	<b>U</b> ₀							
-	ing ph		IF FEMALE:							
O. Box	ie death certif the attending hed for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pro 1 □ Live birth 2 □ 1 4 □ Pregnant at time 9 □ Unknown	Fetal death 3□	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
P.0	The law requires that the digite has been signed by the page 2 should be detached		Part II. Other significant conditions con	ributing to death but not	t resulting in the ur	nderlying cause given	in Part I.	23e. Did tobaco	o use contribute to	the cause of death?
Records,	w requires been sign should be	ed by	ſ					1 🗆 Yes	2 No 3 □ P	robably 4 Unknown
eco	e law requ has been je 2 shouk	Completed						24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
a R								performed	? death?	
Vital	60 KV 77	To Be	25. Was case referred to medical examiner?	ospital:	2 ER/Outpatien	Other	6. Place of Death (6.4 Nursing Home	116	6 □Other (Spe	coto)
n of	£ = =		27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea		28c. Injury at Work?		d. Describe how in		ony)
Division	Attending r death. ector: After by the fune	catle	2 Accident investigation 3 Suicide 6 Could not be			M 1 Yes	s 2 No	Leasting (Street		-10 1
Div	after of Direct of in by	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (Sp	At home, farm, streecify)	eet, ractory, office	281	City or Town, St.	and Number or H ate)	ural Route Number,
	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director:	Medical C	29a. Certifier (Check only one)  1 Cartifying Physical Check only 2 Medical Examin	ician: To the best of my er: On the basis of exa- and manner stated	knowledge, death hination and/or inv	occurred at the time, restigation, in my opin	date and place, and ion, death occurred	d due to the cause at the time, date a	e(s) and manner as and place, and due	s stated. to the cause(s)
	To the Vithiu	ž	29b. Signature and title of certifier	411.	11.0	29c. License n	umber	29d. I	Date signed (Mont	h, Day, Year)
			1 / June	J. AM	SUL	上しば	0814		621	Xo
	10		30. Name and address of person who con			Print)	Tourness MEN (	21204	• 1	
	Sta		Dr. Richard Huslir 31. Date filed (Month, Day, Year)	32. egistrar's S	er Drive	Sulte 302	Towson, MD 2	£14U4		
意	Registr	ar	JUN 0 6 200	O Sucre	D 19					

Division of Vital Records, P.O. Box 68760.

	FOI	partment of Health and Mertificate of Death		5   7730
Physician /Medical	Decedent's Name (First, Middle, Last)  James Joseph Kehl		2. Date of Death Month June 5, 2006	3:03 a. <sup>™</sup>
Examiner	4a. Facility Name (If not institution, give street and number) Gilchrist Center	4b. City, Town, or Location of Death TOWSON		imore Co.
uneral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 2 F 83 Yrs. Usual Residence of Decedent	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year) July 7, 1922 Ma	rthplace (State or Foreign Sountry) aryland
Hind at	10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits 1   Yes 2 □ No
3a or 28 4 be not	10e. Street and Number 5701 Benton Heights Avenue	10f. Zip Code 21206	10g. Citizen of What C	7
Department of regard and wenter hyponous persons are a marked other than 'natural', or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar cant be notified at once.  To Be Completed by Funeral Director		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto f     □ Yes 2  N No Specify:		
yglene. ner than "nature it, the Medical E Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	cedent's Usual Occupation ve kind of work done during most of workin . DO NOT use retired)		s/Industry
Mental Hygie trked other t atic event, th	12 2 yrs.  17. Father's Name (First, Middle, Last)  James William Kehl	Accountant  18. Mother's Name  Mamie	(First, Middle, Maiden Surname) Unknown	
alin ariony 127 ie mar er traumet	1111	illing Address <i>(Street and Number or Rura</i> 1 Benton Heights Av		Zip Code) Maryland 21
nent of ner ant: if item ury or oth	cemetery, c	of Faith Cem. June 7	7,2006 Baltimore	, Maryland
importi eny inj	21. Signature of Funeral Service Liegnsee Mitchael E. Canapp	22. Name and Address of Facility  Leonard J. Ruck, I		ford Road , MD 21214
bysicien and the burial-transit the burial-transit the burial-transit and the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial transit 3a. Part 1. Enter the disease, or complication, that caused the death. Do not eshock, or heart failure. List only be cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, that is leastly to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):			Onset and Death  Won Th	
ed by the ettending physidetached for use as the type of type of type of the type of t		3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of d Month	elivery Day Year
be d	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death? Probably 4 □Unknown
has ye 2			24a. Was an autopsy performed?  1 Yes 2 No 1 Yes	autopsy findings available completion of cause of as 2 \square.
is after death.  al Director: After this certificete ed in by the funeral director, pag  Certification; To Be Co	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	e of y 28c. Injury at Work? M 1 Tyes 2 No	·	ecify) No Sprie
within 24 hours after death. To the Funeral Director: A completely filled in by the tr Medical Certificati	29a. Certifier  (Check only (C	eath occurred at the time, date and place, a investigation, in my opinion, death occurre	and due to the cause(s) and manner and due to the cause(s) and manner and due to the time, date and place, and due	as stated. ue to the cause(s)
To the complet	29b. Signature and title of certifier	29c. License number	29d. Date signed (Moi	
6	30. Name and address of person who completed cause of death (Item 23a) (Type Armon CHML VS M G601 N-	charles It May	7 more 40 212	9
State Registrar	31. Date filed (Month, Day, Year)  JUN 0 6 2006  32. Segistrar's Signature	partie		

			1 - State of Ma	ryland / Depa	artment of H				16	17731	
3	Physicia		Decedent's Name (First, Middle, Last)     ETHEL		KREI	MER	2. Date of Dea Month MAY 31	Day	Year	3. Time of Death 11:15 P M	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) MILFORD MANOR NURSING HOME		4b. City, Town, o	r Location of Death	n		4c. County of Death BALTIMORE		
	Funeral Director			(In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 11/23	/1922	9. Birthp Cour	place (State or Foreign ntry)	
	inyland show			10c. City, Town or Lo	ocation	OUTNOC M	TILC		10d. Inside		
	h the Ma r 28e-f s notifie	Funeral Director	MD BALTIMORE  10e. Street and Number		10f. Zip Code	OWINGS M		l0g. Citizen of W	hat Cour		
	death wit	eral D	322 KEARNEY DRIVE  11. Marital Status 12. Was Decedent E	ver in U.S.   13.	Was Decedent of H	21117  Hispanic Origin? (S	pecify Yes or No-			USA can Indian,	
036	ours after o al', or Iten	þ	Armed Forces?  1 □ Never Married 2 □ Marned 1 □ Yes 2 1 ☑ No.  3 ☑ Widowed 4 □ Divorced Year or Dates:	o	If Yes, specify Cub 1 ☐ Yes 2 💢 No	an, Mexican, Puert	o Rican, etc.)		Specify: WHIT		
21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or Items 23s or 28s-f show any Injury or other traumatic event, the Mudical Exercities must be notified at ONCs.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+	(Give	dent's Usual Occup o kind of work done DO NOT use retire IETOR	during most of wor	rking	DEPARTMI		,	
Maryland 2	id be filed vental Hygie ked other ic event, in	To Be Co	17. Father's Name (First, Middle, Last)  JAKE	KALIN	SKY	18. Mother's Nar	ne (First, Middle,	Maiden Sumame	э)	FRIEDMAN	
Mary	d 2 shouth and No. 7 le mai		19a. Informant's Name/Relationship (Type, Print) BRUCE KREMER / SON		ng Address (Street KEARNEY						
	jes 1 end of Health if Item 27 or other to		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 ☒ Removal from State	20b. Place of Disp		сө)	Date	20c. Location - (	City or To	own, State	
Baltimore,	nit. Pag sertment ortent: Injury o		4 Donation 5 Other (Specify)  21. Signature of her Service Licensee	EMANU-EL	CEMETERY 2. Name and Addre		)2/2006 DL LEVIN:				
ä	Depe Impo any l		23a. Part1. Enter the disease, or complications that caused		3900 REIS	TERSTOWN	ROAD - I	PIKESVIL		MD 21208	
	Physician		shock, or heart failure. List only one cause on each line	nrambotic		g, 55511 45 541 5141	o roophulory ur	5011		Approximate Interval Between Onset and Death	
8	/Medical Examiner		Due to (or as a	consequence of):				_			
J	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	consequence of):							
> '092	sician and burial-transit	ical Exar	that initiated events resulting in death) Last								
9	9 × e		IF FEMALE:								
P.O. Box	that the death certificat ed by the attending phy detached for use as th	Physician/Med	23b. Was decedent pregnant 1 Live birth	Was decedent pregrent in the past 12 months?  1 Yes 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N						ery Day Year	
	sign Sign I be	þ	Part II. Other significant conditions contributing to death but	t not resulting in the o	underlying cause gr	ven in Part I.				he cause of death?	
Division of Vital Records,	The ete h page	Completed			7.7.7		24a. Was autop perior 1  Yes	med? d	rior to co leath?	opsy findings available impletion of cause of	
Vita	Phyelcien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatier	nt 2 ☐ ER/Outpatie	nt 3□ DOA Ot	nor /	ath <i>(Check only o</i> Home 5 ☐ Resid		er (Specii	(v)	
o uo	ding Ph h. After the funeral		27. Manner Death  1	Year) 28b. Time (	Wo			ow injury occurre			
Divisi	l or Attending effer death. Director: Affer I in by the fune	Certification:	a Country 6 Could not be	ry - At home, farm, si . (Specify)			28f. Location (S City or Tox		er or Rura	al Route Number,	
	To the Hospitel or Attending Ph within 24 hours eiter death. To the Funeral Director: Atter th completely filled in by the funeral	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of Physician: To the best of and manner star	examination and/or in							
	To the within 2 To the complet	Me	29b. Signature and title of certifier  **NS/(W) wpame N(1)		29c. Licen	se number 57465		29d. Date signed	(Month,		
	6		30. Name and address of person who completed cause of de	eath (Item 23a) (Type	ain St, 8	ivite 200	) Reisten	stown, M	1D. 2	21136.	
	St Regist	ate rar	31. Date filed (Month, Day, Year) 32, Registra	r's Signature							

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/illiam Franklin	1 F	- For State		ate of Mary	land /		tment o			a ivienta			Reg No	. 20	06	)	177
Physicia Medical Examir	ner	1. Decedent's Name Willia	m Frank	lin Latimo	re					<del>,</del>		Date of De Month June 4, 2	Day 2006			1814	
	н	4a Facility Name (if		n, give street and i Marlboro Roa					ol Heig	Location of hts	t Death		ľ	4c. County of Do Prince Geo			
Funeral Director		5. Social Security Nu	umber	6. Sex			st birthday)	Month	er 1 Year	<del></del>	Mın.		,		Birthporeign Count		
	ŀ	247-98-9238 Usual Residence of	Decedent	1X M 2 F		50	) 1	rs.				12-03-	1955				SC
w any			10b. County			IOc City, T	own or Loc	ation									e City Limits s 2 X No
vlaryland 28a-f show any d at once.	횽	MD 10e. Street and Num		ce George's	5		Fort	Washing 10f. Zip					10g. C	itizen of What (			
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AD 21215-0036 2 should be filed within 72 h and Mental Hygiene. 27 is marked other than "	e Be	Tony La		ship (Type Print )			19h Mail	ina Addres:	s /Strac	Wi	illie I	Mae Cur	nning	cham City or Town, S	State 7	in Code)	
and 2 shoul tealth and N tem 27 is n traumatic	ř	Leslie Lati			hter									23188	ridio, z	ip oode)	
<b>∠</b> ₽ Ξ = ₹	Ì	20a. Method of Disp		n 3 Remova	I from Stat		lace of Disp ematory or	osition (Na	me of cer	metery,	[	Date	200	Location - Cit	y or To	wn, State	е
Baltimore, permit Pages I an Department of Hea Important: If iter		4 Donation 5	Other S	pecify			ary Men				06-10-	-06	Lá	urens, S	C		
Baltimo permit Page Department of Important: injury or oth		21 Signature of Fur		Licensee				. Name and		,		C: 1	· · · · ·	. Balto,	100	0101=	
Physician	$\dashv$	23a. Part I. Enter th failure. List onl			t caused t	he death.	Do not ente	r the mode	of dying,	such as ca	ardiac or re	espiratory a	or SI arrest, s	hock, or heart	MD		/ mate Interva n Onset and
/Medical Examiner	5 Y	Immediate Cause (I or condition resulting	Final disease	a Multiple I											-4		Death
Norman		Sequentially list cor		Due to (or a	s a conse	quence of)	):								====		
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Division of Vital Records, P.O. Box 63760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/Medi	IF FEMALE: 23b. Was decedent	pregnant in t	the contract	es, outcom	e of pregn		Fetal death	3	Ectopic	pregnanc	:v	2	23d Date of del Month	ivery Day	,	Year
th certi	iciar	past 12 months		4 Pre	egnant at 1	time of dea		Other (Spe			program:	,					
b. Bo the dea by the a	Phys	Part II. Other signi		9011	known g to death	but not re	sulting in th	e underlyin	g cause	given in Pai	art I.	23e. Dio	d tobacc	co use contribut	e to the	e cause o	of death?
P.C res that signed be deta	d by	<u> </u>										1 🔲 ነ	Yes 2	<b>✓</b> No 3	Probab	oly 4	Unknown
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Hospit:		4 Homicide 29a. Certifier (Check only	Certifying F	Physician: To the	best of my	/ knowledg	ge, death oc	curred at th	ne time, d	late and pla	ace, and de	ue to the ca	ause(s)	and manner as	started		a, Gapitai
Division of Vital To the Hospital or Attending Physician: within 24 hours after death To the Forneral Director: After this certif completely filled in by the funeral director.	Medical	one) 2		aminer: On the bas and mann	sis of exar er stated	mination ar	nd/or investi				curred at t	he time, da					
	Σ	29b. Signature and	title of certif	ier /	14			29		se number				Date signed une 5, 2006	•	ı, μay, Υε	iar)
		30. Name and addr	ress of perso	n who complete	ause of d	eath (Item	23a)										
2		Jack Titus I	14.	puty Chief Me	dical E	xaminer	111 F	_		Itimore, I	MD 212	01					
S Regis	tate		th, Day, Year	32	Registra	r's Signatu	P. 1	Market St.									

1_ 8	For State of M State Registrar	aryland / Department of Health and I Certificate of Death	Mental Hygien	4000 11133
1. De Physician	ecedent's Name (First, Middle, Last)		2. Date of Death Month D	Day Year S 05 M
/Medical Examiner 4a.Fa	acility Name (If not institution, give street and number,	4b. City, Town, or Location of Death		4c. County of Death
K	Soland Park Park Park Park Park Park Park Park	ge (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8 Date of Birth	Birthplace (State or Foreign
Funeral 21	3-12-6838 1 M 2 DF	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	917 Maryland
Usua 10a. S	Al Residence of Decedent State 10b. County	10c. City, Town or Location		10d. Inside City Limits
the Marylan 108.5	MD	Baltimore		1 ☐Yes 2 ☐ No
Inter deeth with the Martine deeth with the Martine Tritiene 23e or 28e-1 e Inter Trust be notified.  Funeral Director	Street and Number 40th St	10f. Zip Code	10g. 0	Citizen of What Country?
deeth v	Marital Status 12. Was Decedent Armed Forces	Ever in U.S. 13. Was Decedent of Hispanic Origin? (Signer) If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - American Indian, Black, White, etc.
8 8 8	□ Never Mamed 2 □ Married 1 □ Yes 2 □ If Yes, Give Year or Dates:	No 1 □ Yes 2 ☑ No Specify:		specity: White
15-0036	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of wor	king 16b.	Kind of Business/Industry
L 21215-00	ementary/Secondary (0-12) College (1-4or	5+) life. DO NOT use retired)	4	US Government
re, Maryland 212.  s 1 and 2 should be filed within the Health and Mental Hygiene. It Health and Mental Hygiene other transmitte event, the Meryland of the Health and Mental Health and He	Father's Name (First, Middle, Last)	18. Mother's Nan	ne (First, Middle, Maide	
Maryland d 2 should be filted d 2 should be filted d 2 should be filted The and Mendal by traumatic event To Be (	Informant's Name/Relationship (Type, Print) (Ex	19b. Mailing Address (Strey and Number or Ru	ral Route Number, City	OTEN  Vor Town, State, Zip Code) 2120 -
19ad 2 she Health and 2 she Health and 2 she she she are she as 18ad 2 she she she she she she she she she she	lary Taliaferro	gend) 19b. Mailing Address (Strey and Number or Ru 13212 E. Techoa	nk rd. I	3altimore mo
OL Sell His Table 1 20a.	Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c.	Location - City or Town, State
그 트로크	4 □Donation 5 □Other (Specify)  Signature of Funeral Service Licensee	Mt. Olivet Cemetery 6-1	lans fur	aprillore City
_ db d	Kenneth C Spek	8800 Harford rd	Parkvil	le, mo 21234
A second	<ul> <li>Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each nediate Cause (Final</li> </ul>		or respiratory arrest,	Approximate Interval Between Onset and Death
/Medical resu		Dementia s a consequence of):		
Examiner Sequ	uentially list conditions.	nultiple infarcts		
Caus	se. Enter Underlying sise (Disease or injury initiated events c			
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Box 68 eath certifica ettending pl for use est to consecutive cons	. Was decedent pregnant in the past 12 months?	e of pregnancy  2   Fetal death   3   Ectopic pregnancy at time of death   5   Other (specify)		23d. Date of delivery  Month Day Year
P.O. Box 68 that the death certific ed by the ettending p detached for use est r Physician/Med	9 Unknown			
	II. Dther significant conditions contributing to death  FAILURE TO	but not resulting in the underlying cause given in Part I.  Thrive		o use contribute to the cause of death?  2 No 3 Probably 4 Unknown
Division of Vital Records, or attending Physician: The law requires to after cleath.  Director: After this certificate has been signed in by the tuneral director, page 2 should be ertification: To Be Completed by			24a. Was an	24b. Were autopsy findings available prior to completion of cause of death?
Il Rec			autopsy performed?	Ro 1 Yes 2 No
of Vital F hysician: The hysician: The his certificate all director, pag.	Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpat	O+	ith (Check only one)  Iome 5 Residence	6 ∏Other (Specify)
ding Physical Control of the control	Manner of Death 28a. Date of Inj  Natural 5 □ Pending (Month, D	ury 28b. Time of 28c. Injury at Work?	28d. Describe how in	
Division Category State of Attending Part Geath.  al Director: After the duners ed in by the tuners  Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Ir	M 1 ☐ Yes 2 ☐ No	28f. Location (Street	and Number or Rural Route Number,
Div Ital or / Ital 4   Hornicide Dullding, 6	tc. (Specify)	City or Town, Sta		
Division of Vital Reports to the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate hy completely filled in by the funeral director, page Medical Certification; To Be Com	. Certifier 1 ☐ Certifying Physician: To the bes (Check only 2 ☐ Medical Examiner: On the basis one) and manner s	t of my knowledge, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occu- stated.	e, and due to the cause arred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
Within Topmon A 59p.	. Signature and title of certifier	29c. License number	_	Date signed (Month, Day, Year)
	Name and address of person who completed cause of	death (Item 23a) (Type Brint)		me 5, 2006
0 1.	tilary DON m.D. 831	WEST FORTIETH STREET	BALL	more mary lang
State State Registrar	Date filed (Month, Day, Year) 32 Agis	trar's Signature		

DHMH 17 Rev 1/2001

		-	For State of Registrar	Maryland / Dep	ertificate of L	Death	Reg. I	2000	17734
	Physicia		1. Decedent's Name (First, Middle, Last)			2	Date of Death Month 05 3	2006 ar	3. Time of Death
	/Medic	al	Sandra Shaw Lukens  4a. Facility Name (If not institution, give street and num	her)	4b. City, Town, or	Location of Death		4c. County of Death	8:06pm M
	Examin	er	Holy Cross Hospital	201)		Spring		Montgon	
	Funeral Director		187-28-9860	7. Age (In yrs, last birthday 70 Yrs.	// If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Ye 11-11-19	9. Birth Cou Penr	nplace (State or Foreign untry) 18y1vania
	land ow	}	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L					10d. Inside City Limits
	Mary a-f ah	tor	MD Montgomery	Silver	Spring				1 ☐ Yes 2 No
	or 28	Direc	10e. Street and Number		10f. Zip Code	2000/	10g.	Citizen of What Cou	untry?
	eath v	erai	12629 Springloch Ct.  11. Marital Status 12. Was Dece	dent Ever in U.S. 13	Was Decedent of Hi	20904	fv Yes or No-	14. Race - Amer	ican Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itama 23a or 28a-f ahow any Injury or other traumatic avant, Ira Medical Endiring must be notified at ange.	Completed by Funeral Director	Armed For 1 Never Married 2 Married 1 Yes It Yes, Giv Year or Da	No.	If Yes, specify Cubain	spanic Origin? (Speci n, Mexican, Puerto Ri Specify:	can, etc.)	Black, White Specify: Whi	
2-0	72 ho natur	eted	15. Decedent's Education (Specify only highest grade completed)	(Giv	edent's Usual Occupa e kind of work done of	turina most of working	16b	. Kind of Business/l	ndustry
121	within ene. then	iduc	Elementary/Secondary (0-12) College (1	4or 5+)	DO NOT use retired, chool Teac			Educati	lon
1d 2	i Hygi other	Be Co	17. Father's Name (First, Middle, Last)			18. Mother's Name (			
ylar	should be ind Mental I	To E	John Thomas Shaw				nrietta		
, Maryland 21215-0036	1 and 2 shi Health and tam 27 is m	1	19a. Informant's Name/Relationship (Type, Print) Jennifer L. Lovelett/da	1262	29 Springl	och Ct. Si	lver Spr	ing MD 20	)904 
Baltimore,	Pages 1 nent of He ant: If Itan ury or oth		20a. Method of Disposition 1 ☐ Burial 22☐Cremation 3 ☐ Removal from 5 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disp cemetery, critical Chesapea	position (Name of ematory or other place ake Cremat	ory 06-05		Location - City or 1 eltsville	
Balt	permit. Departr Importe any Inje		21. Signature of Funeral Service Licenses	1358	22. Name and Addres Rapp Fun 933 Gist	eral & Cre Ave Silve	mation S er Spring	ervice MD 20910	)
			23a. Part1. Enter the disease, or complications that conshock, or heart failure. List only one cause on example 23a.	ich line.		g, such as cardiac or r	respiratory arrest,		Approximate Interval Between Onset and Death
,	Pnysician /Medical	6 1	disease or condition resulting in death)	cardial Infa	arction				
	Examiner			or as a consequence of):					
	p =	ner	Sequentially list conditions, and the sequentially list conditions, but leading to immediate cause. Enter Underlying Cause (Disease or injury	or as a consequence of:					
	icate be executed physicien and s the burial-transit	Examiner	that initiated events c.	or as a consequence of):					
8760,	sicien buria	cai E	4						
9	tificate ig phy as the								
.O. Box	st the death certificate be executed by the ettending physicien and tached for use as the buriat-transit	Physician/Med	in the past 12 months?	ant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of delin Month	very Day Year
Vital Records, P.	es thet gned b be deta	۵	Part II. Other significant conditions contributing to de History of Obstructive		underlying cause give	en in Part I.			the cause of death?
900	law requir ss been si 2 should	Completed	Bipolar Disorder				24a. Was an autopsy	24b. Were aut	topsy findings available ompletion of cause of
E B		Com	Hypertension				performed 1 ☐ Yes 2€	? death?	2□ No
Vita	Physician: r this certific ral director.	Be	25. Was case referred to medical examiner?		ent 30 DOA Othe	26. Place of Death (			
ō	Phys ar this aral dii	. To	1 tes 2/2 1/40 1 2/4	npatient 2 ER/Outpatient Injury 28b. Time Injury Injury	of 28c. Injury	4   Industry Home	<ul> <li>5 ☐ Residence</li> <li>d. Describe how in</li> </ul>	6 □Other (Spec	ufy)
ion	utanding I death. ctor: After y the funer	atio	2 Accident investigation	h, <i>Day Yeer)</i> Injury		(? Yes 2 □ No			
Division of	al or Attending s after death. Il Director: After id in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place buildii	of tnjury - At home, farm, s ng, etc. <i>(Specify)</i>	street, factory, office	28	f. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
	To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th	ledical C	29a. Certifier   1   Certifying Physician: To the (Check only one)   2   Medical Examiner: On the band mann	sis of examination and/or					
	withir comp	Me	29b. Signature and title of certifier	N/2 0-	29c. License		29d.	Date signed (Month	
,	7		> Wikkman J	· IVIVIAVA	D452	.85		06-02-200	)6
10	)		30. Name and address of person who completed caus Wilkenson J. Ninala MD	344 Universi	ty Blvd. #	113 Silver	Spring	MD 20901	
	Sta Registi			egistrar's Signature	porte				

							of Health and		_	17725
		•	1 - State Registrar				of Death		Reg. No.	11133
15		4	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day Year	3. Time of Death
* *	Physicia /Medic		Rose	М.		Long		June	1, 2006	3:50 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give s	street and number)			vn, or Location of Dea	th	4c. County of Deat	
	***		Riverview Nurs		(la usa la at histoda u	Ess If Under 1 Y		S. R. Date of Bird	Baltimo	Dre hplace (State or Foreign
£ ,	Funeral Director		5. Social Security Number 6. Sex 220-01-1175	M 2∭TF	(In yrs. last birthday) 85 Yrs.		ays Hours Min	(Month, Da	v. Year) Co	higan
. ···	ж.		Usual Residence of Decedent							
	yland		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Ba-fs	cto	Maryland Baltimo	re	Dund	alk				1 Tyes 2 XNo
	or 20	Director	10e. Street and Number			10f. Zip Co	de   222		10g. Citizen of What Co USA	untry?
	172 hours after death with the Maryland "natural", or Itema 23a or 28a-f show adical Examinar must be rediffed at	rai	1612 Rita Road	12. Was Decedent E	vor in II C 13			Specify Ves or No		ncan Indian
	item item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	0.3.	If Yes, specify	of Hispanic Origin? ( Cuban, Mexican, Pue	rto Rican, etc.)	_	e, etc.
336	urs af	by	3 Widowed 4 □ Divorced	1 □ Yes 27 No If Yes, Give Year or Dates:		1 ☐ Yes 🂥	No Specify:		Specify: Wi	nite
9	2 hor	Completed	15. Decedent's Edu (Specify only highest grade		16a. Dece	dent's Usual O	ecupation	orkina	16b. Kind of Business/	Industry
215	c • a	npie	Elementary/Secondary (0-12)	College (1-4or 5+	-)		done during most of wo etired)	9		
21	be filed within tal Hygiene. d other than avent, the M	S	7 years			Laborei		mo /First Middle	Western Ele	ectric
and	o a b e	Be	17. Father's Name (First, Middle, Last)					Stanko	, Maldell Sumame,	
2	d 2 should be th and Menta 7 Is marked traumatic av	ဥ	John Havlicek  19a. Informant's Name/Relationship (Ty	oe Print)	19b. Maili	na Address (S			er, City or Town, State, 2	Zip Code)
Maryland 21215-0036	12 s h ar 7 is trau		William Long	son					sville, MD.	
ē,	s 1 and 2 f Health item 27		20a. Method of Disposition		20b. Place of Disponentery cre	osition (Name i	of	une 6,	20c. Location - City or	Town, State
E C	Page ient o nt: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Bayview			006	Baltimore (	City, MD.
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2: any injury or other?		21 Signature / Funeral Service Licens	9/	2	2. Name and A	Address of Facility	Home Of I	Dundalk,P.A. Dundalk,MD.	
Ω_	89 E E 9		John Emle	6/						
		d	23a. Part). Enter the disease, or compleshook, or heart failure. List only or	ications that caused the cause on each line	the death. Do not en e.	ter the mode o	f dying, such as cardia	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
1.0	Physician		Immediate Cause (Final disease or condition resulting in death)	Metacta	he volva	r can	rer			
	/Medical Examiner		resulting in dealisy	Due to (or as a	consequence of):					
		ē	Sequentially list conditions,	Due to (or as a	consequence of):					
	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
ď.	te be executed ysicien and ne burial-transit	Exa	resulting in death) Last	Due to (or as a	consequence of):					
190	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	icai		d						
89	leath certificate I attending physi	Physician/Medi	IF FEMALE:							
Box	ath ce ttendi or use	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth	2 ☐ Fetal death 3	⊒Ectopic pregr			23d. Date of del Month	livery Day Year
0	the a	/sic	1 ☐ Yes 2 █ <b>\$</b> No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	ime of death 51	Other (speci	<i>Ty)</i>			
α.	thal the de ed by the detached	P	Part II. Other significant conditions co	ntributing to death bu	t not resulting in the	underlying caus	se given in Part I.	23e. Did t	obacco use contribute to	the cause of death?
ds	uires tha signed I Id be det	d by	Hypoteusin					1 🗆	Yes 2 □ No 3 □ Pr	obably 4 Unknown
00	w requir	ete	donecto					24a. Was	an 24b. Were au	utopsy findings available
Re	he la le has age 2	Completed	Certain		<del></del>			autoj perfo 1 ☐ Yes	ormed? death?	completion of cause of
ta	an: Trifical	0	25. Was case referred to medical	**			26. Place of De	eath (Check only)		2010
f V	nysici nis ce direc	ToB	examiner? 1 Tyes 2 No	Hospital: 1 🗆 Inpatier	nt 2 ER/Outpatie	nt 3 DOA	Other: 4 Nursing	Home 5 ☐ Resi	dence 6 □Other (Spe	cify)
0 0	ng Pt Iter tt Ineral	::0	27. Manner of Death 1	28a. Date of Injun (Month, Day	Year) 28b. Time (		. Injury at Work?	28d. Describe	how injury occurred	
Sio	tendi leath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be			М	1 ☐ Yes 2 ☐ No	006 1	(644	(0)
Division of Vital Records,	or At ifter d Direct in by	Certification:	4 Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, s . (Specify)	reet, factory, o	ffice	City or To	Street and Number or Ri wn, State)	urai Houle Number,
_	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Phy	sician: To the best of	f my knowledge, dea	th occurred at	the time, date and place	ce, and due to the	cause(s) and manner as	s stated.
	24 h	Medical	(Check only 2 Medical Exami	ner: On the basis of	examination and/or in	nvestigation, in	my opinion, death occ	curred at the time,	date and place, and due	to the cause(s)
	To the To the To the Somple	Me	29b. Signature and title of certifier			29c. L	icense number		29d. Date signed (Mont	h, Day, Year)
			Thread lieu	anne		D	19667	10000	06/0-2-2	000
1			30. Name and address of person who c	ompleted cause of de	eath (Item 23a) (Type	, Print)	L am	na Gte	n Berie 170	unland
(	) (		Thurst Sunsa	uz peo	1210 Petr	hierty	may +S	08	21	061
	St Regist	ate rar	31. Date filed (Month, Day, Year) JUN 0 6 20	06 32. Registra	w B A	mark!			29d. Date signed (Mont 06°0°2 - 2: M. Bernier 770 21	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 3:20 PM Audrey Mae Lassiter <u>June</u> 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1849 Portship Road Dundalk Baltimore Co. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 M 2 XF Yrs Jan. 3,1929 Director 227-32-0567 Virginia Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylar nant of Health and Mental Hygione. assirt if item 22a or 28a-f ehow ast: If item 27 is marked other than "natural; or items 23a or 28a-f ehow ury or other traumatic event, the Madical Example must be notified as 1 ☐ Yes XXNo Director Dundalk Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1849 Portship Road 21222 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status be filed within 72 hours after de lal Hygiene. d other than "natural", or Item 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify ð 3 ☐ Widowed 4 💯 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6 Years Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) William L. Johnson Susie Benton 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jennifer Heck (Daughter) 1849 Portship Road Dundalk, Maryland 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 Ø Cremation 3 ☐ Removal from State permit. Page Deportment Important: If any injury or 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp. 6/7/2006 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 2 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** Ventriculus Arrhythma /Medical Due to (or as a consequence of) Examiner House school Carlie Vascily Bisce's Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 Onknown XPSIS Completed welli 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has t autopsy performed? Yes 2 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 1 ☐ Yes 2 No 1 Inpatient 5 Residence 6 □Other (Specify) ို 2 ER/Outpatient 3□ DOA this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death. 2 Accident 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral DI completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 2 039660 Dure 5, 2006 wte-12m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bulti more 1201 CUM, Point 21219 NOVEN racelo 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUN 0 6 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Physician TUSTUS 1 STTS 40 04 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Manor Care Rossville Rossville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 10 2 F Yrs Director 03 88 Apr. 9, 1918 New York Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f ehow other traumatic event, the Modical Examiner must be notified at 1 Yes 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 411 Cedar Springs Road 21015 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: ģ 3 Widowed 4 Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Aircraft Manufacturer Plant Superintendent permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, important: if flem 27 is marked othe eny injury or other \*\*\* 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clara Hipperling Samuel J. Letts (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard S. Letts / son 8305 River Trail Lane, Bethesda, MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp. 6-5-06 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Candianyo pathy. Examiner Schemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as i IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s certificate has performed a⊟ No e No 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 1 Yes 1 Inpatient 2 ER/Outpatient Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signarure and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) pleted cause of death (Item 232) (Type, Prince 31. Date filed (Month, Day, Year) **B**gistrar's Signature State JUN 0 6 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Day 2006 Month **Physician** АМ April 24, 3:38 Mary McMurrer /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 9800 Lemocks Drive Upper Marlboro Prince Georges If Under 1 Year If Under 24 Hrs.
Wonths Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6 Sax 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 ☐ M 2 🖾 F Vrs 46 Jan 23, 1960 Director WV 216-82-8501 Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD Prince Georges Upper Marlboro 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number ō 9800 Lemocks Drive or items 23a 20772 death y Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or iten any injury or other traumatic event, the Medical Examera 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 💆 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk Etementary/Secondary (0-12) College (1-4or 5+) Operations Assistant 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Robert Arnold McMurrer Joan Ellen Vallandingham 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9800 Lemocks Drive Upper Marlboro, MD 20772 Joan Ellen McMurrer/mother 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☑Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 21. Si natura of Funeral Service Ucensee Renald S. Wade mun Approximate tnterval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Funa **Physician** montas 9 /Medical Due to (or as a consequence of **Examiner** 0, Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed the attending physicien and hed for use as the buriat-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ After this certificate has been signed funeral director, page 2 should be 1□Yes A□No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy No 2□ No 1 Tyes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 170 4 ☐ Nursing Home Sesidence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation the 1 within 24 hours after deat To tha Funeral Diractor: 6 Could not be determined 3 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide To the Hospital 29a. Certifier 1 Acritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) ertifier 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 650 OCLEANS Gone STEVEN 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 0 6 2006

State of Maryland / Department of Health and Mental Hygiene) For State Registra Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Year Month **Physician** 4:05 AM June 2 2006 Miller /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Union Memorial Hospital Baltimore If Under 1 Year | ff Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours Months 1 ☐ M 2X F 92 Yrs 215-01-7848 12-10-1913 MD Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. fnside City Limits 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural; or items 23a or 28a-1 ehow any injury or other traumatic event, the Madical Examinat must be notified at once. 1 ☐ Yes 2 1 No Director Anne Arundel Severna Park 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 43 West McKinsey Drive 21146 U.S.A. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Black, White, etc. I ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White 3 X Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumame) Be John Vinson Willard Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Nancy Bandiere / daughter 1321 Park Avenue; Baltimore, MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 
☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Chesapeake Cremation 6-3-2006 Stevensville, MD 22. Name and Address of Facility Singleton Funeral Home, PA 21. Signature of Funeral Service Licenses Moi357 1 Second Ave SW; Glen Burnie, MD 21061 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition cardia Physician Brady minutes resulting in death) /Medical Due to (or all a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events o (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit 110 aud resulting in death) Last P.O. Box 68760, been signed by the attending physicien a should be detached for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetaf dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetaf death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. þ Division of Vital Records, 3 Probably 1 Yes 2 No Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No this certificate 2 No 1 Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Vinpatient Certification: To 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After 1 ENaturaf Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ATZ438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) h Memorial Hospital VNION 32. Projetrar's Signature State 31. Date filed (Month Registrar

06-03681 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Paul Joseph Malone, Jr 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Day May 30, 2006 PAUL JOSEPH MALONE, JR. 0842 hrs Medical Examiner 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore County** 8017 Eastdale Road Colgate If Under 24Hrs. 8 Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days Hours Months Director 217-88-3674 Country) MARCH 18, 1967 MD. 1 XM 2 39 Usual Residence of Decedent Oc. City, Town or Location 10d Inside City Limits any 10a State 1 Yes 2 X No s 23a or 28a-f show e notified at on<u>ce.</u> 28a-f show EASTPOINT MD. BALTIMORE Pages 1 and 2 should be filed within 72 hours after death with the Maryland iment of Health and Mental Hygiene. 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21224 UNITED STATES 8017 EASTDALE ROAD Funeral 13. Was Decedent of Hispanic Origin? ( Specify Yes or No 11. Marital Status 12. Was Decedent Ever in U S Race - American Indian, Black. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White etc. 1 X Never Married 2 Married Yes 2 X No WHITE If Yes, Give Year Yes 2 X No specify: 3 Widowed 4 Divorced Specify Examiner ğ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Completed College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 h Department of Health and Morntal Hygiene. Important: If item 27 is marked other than "n injury or other transmatic event, the Madrial E 27 is marked other than matic event, the Medical ROOFING ROOFER 0 12TH 7. Father's Name (First, Middle, Last 18 Mother's Name (First, Middle, Maiden Surname) VIRGINIA LEE FRAZIER PAUL JOSEPH MALONE, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8017 EASTDALE RD., BALTIMORE, MARYLAND 21224 19a. Informant's Name/Relationship (Type, Print) PAUL J. MALONE, SR./FATHER 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 6/5/2006 BALTIMORE, MARYLAND GARDENS OF FAITH Donation 5 Other Specify. 21 Signature of Funeral Service Licensee 22. Name and Address of Facility 22 Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 Ivan dis se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and falure. List only one cause on each line. /Medical Death Hypertensive cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical AMENDED item#23a,27,perME,g856,6/14/06 TT physician the burial -X UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23b Was decedent pregnant in the 23d Date of delivery 23c. If yes, outcome of pregnancy Live birth 3 Ectopic pregnancy Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 ✔ Unknown 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy this certificate has performed? death? ✓ Yes 2 2 No 1 🗸 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Inpatient 2 Other4 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 V Yes 2 2 No 28a. Date of Injury (Month, Day, Year) 28d Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No 5 Pending the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 31, 2006

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Name and address of person who com Hered cause of death (Item 23a)

Assistant Medical Examiner

32. Redistrar's Signature

Laron Locke MD

JUN 0 6

			State of Maryland / Department of Hea  1 - State Registrer			ene 006	17741					
	Physici	an	Decedent's Name (First, Middle, Last)     George Paul Mifsud		Date of Death     Month	Day Year	3. Time of Death					
	/Medic	al	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Local Control of the City, City, Town, or Local Control		June	3 2006 4c. County of Dea	10:14 P. <sup>M</sup>					
	Examin	er	Joseph Richey Hospice  Baltimor			N/A						
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If U	Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day, ) Aug. 11,	(ear) Co	chplace (State or Foreign buntry) W York					
	and *		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location				10d. Inside City Limits					
	Maryl. f sho	tor	Maryland Anne Arundel Glen Burnie				1 ☐ Yes 2 📉 No					
	death with the Maryland ms 23a or 28a-f show rmust te rwitted at	Funeral Director	10e. Street and Number 302 Blue Water Court Apt. 202 21060	0	100	g. Citizen of What Co U.S.	ountry?					
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic event, the Madical Examinat must be revisited at once.	/ Funer	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Never Married 2 ☑ Married If Yes, Specify Cuban, M If Yes, Sive TRITT I Yes 2 ☑ No If Yes, Give TRITT I ☐ Yes 2 ☑ No	nic Origin? (Spe Mexican, Puerto I Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.					
5-0036	hours tural',	ed by	3 Wildowed 4 Divorced Year or Dates: WW 11		16	6b. Kind of Business	/Industry					
	in 72	plet	(Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired)	ng most of working	ng							
2121	ed within /giene. er than "	Completed	4 years C.P.A.				Industries					
0 14 yland	buld be fill Mental Hy arked oth	To Be	Anthony Mifsud	Mary	(First, Middle, Ma Caruana							
Mar	12 sh h and 7 le m traum		19a. Informant's Name/Relationship (Type, Print)  Dorothy Mifsud / wife  19b. Mailing Address (Street and the street									
e,	Healt tem 2		20a. Method of Disposition 20b. Place of Disposition (Name of			Oc. Location - City or						
	Pages ent of nt: If i		1 \ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Holy Cross Cemetery	6/7/	2006 Ba	altimore,	Maryland					
6/3/06 Baltimore,	permit. Departm Importa any inju		21. Signature of Funcial Service Licenses  4001 Ritchie									
9	Physician /Medical		Approxim Interval B Conset and Steady of Cancer Condition (resulting in death)  Approxim Interval B Conset and Cancer Condition (resulting in death)  Approxim Interval B Conset and Cancer Condition (resulting in death)  Due to (or as a consequence of):									
J.	Examine be executed ysician and he burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):  d.				_					
FSW.	death cert e attendin id for use	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \) 9 \( \text{Unknown} \) Unknown  23c. If yes, outcome of pregnancy 1 \( \text{Live birth} \) 2 \( \text{Fetal death} \) 3 \( \text{Ectopic pregnancy} \) 5 \( \text{Other (specify)} \)			23d. Date of de Month	livery Day Year					
M. i	uires that n signed b		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Diabetes	n Part I.			o the cause of death?					
P. /		Completed			24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of					
Vital (		BeC	avaminar?		Check only one	/	17					
50	Phys rald	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Office.  27. Manner of Death 1 Notural 5 Pending (Month, Day Year) 28b. Time of Injury Work?		me 5 Residen 28d. Describe hov		ocity) Hospice					
EOT Division	i Diffe	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,					
6	Hospital  24 hours a  Refunaral E	edical C	29a. Certifier (Check only one)  1. Certifying Physicien: To the best of my knowledge, death occurred at the time, of examination and/or investigation, in my opinion and manner stated.									
	To the I within 2 To the I complet	M	29b. Signature and title of certifier 29c. License nu	umber	29	d. Date signed (Mon	th, Day, Year)					
	-61		2 180 MD	1170	J	une 5, 2	006					
١.	157		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  E. TSO MD Richer Hospice	838 N	1. Eutan	J Balti	MORE MD					
	St Regist	ate rar	31. Date filed (Month, Day, Year)  32. Date filed (Month, Day, Year)  32. Date filed (Month, Day, Year)									

			State of Maryland / Department of Health and Certificate of Death	Mental Hy	giene 2	306	17742
			Decedent's Name (First, Middle, Last)	2. Date of D	eath		3. Time of Death
	Physici		John Thomas Massey	Month	Day	2 (V)	5:45 am
	/Medic Examir		4a Facility Name (If not institution, give street and number)  4b City, Town, or Location of Deat	h	4c. Coun	ty of Death	
			Franklin Sougre Hospital Kosedale		to	iltim	sre
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 2.1.7 - 2.4 - 6.6.0.7 10 Months Days Hours Min.	(Month, D	rth ay, Year)	9. Birthr	place (State or Foreign ntry) ULANd
	Director		217-34-0807	Nov. 2	1, 1937	Mar	ykand
	and w		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location				10d. Inside City Limits
	daryl f aho	ō	Maryland Baltimore Perry Hall				1 ☐ Yes 2 No
	the t	Director	10e, Street and Number 10f, Zip Code		10g. Citizen of	What Cou	ntry?
	3a or		8934 Cowenton Avenue 21128		u	.S.A.	
_	ours after death with the Maryland rai', or lieme 23e or 28e-f ehow Exa niner nast be notified et	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	Specify Yes or N		ace - Americ	
~ w	<u> </u>	교	1 □ Never Married 2 X Married 1 □ Yes 2 X No	to Hican, etc.)		ack, White,	
3	ral', c	1 by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		Spec	ity: Wi	hite
50	within 72 hours after ene. then "natural", or Ite he Madical Executor	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of wo	rking	16b. Kind of		
1 7 <u>2</u>	Aithin hen	du	Elementary/Secondary (0-12) College (1-4or 5+)		Self-En		
~ 2	led v tygie her t		12 Owner  17. Father's Name (First, Middle, Last)  18. Mother's Na.	ma (Eiret Middle			caping Co.
55eV, $Joh$ Marvland 21215-0036	ges 1 and 2 should be filed within 72 ho of thealth and Mental Hygiene. If Item 27 is marked other than "nature or other traumatic event, the Madical	Be c	Rawlings H. Massey Emma	Anders		me	
Z Z	Should Me	ဍ	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ri			n, State, Ziţ	Code)
\\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\	and 2:		Katherine Anita Massey (wife) 8934 Cowenton Avenue,	Perry 1	Hall, MI	211:	28
- E	S 1 au of Hea item othe		20a. Method of Disposition  20b. Place of Disposition (Name of cametery, crematory or other place)	Date	20c. Location	- City or To	own, State
M Q	permit. Pages Department of Important: If I any Injury or one		1	2006	Fuller	ton. I	Maryland
<u> </u>	permit. Pa Departmen Important: any Injury once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility S				
Ω	Peril Many Pany Pany	1	Beran a. Celle 9705 Belair Rd., B	altimor	e, MD 2:	1236	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial shock, or heart failure. List only one cause on each line.	c or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Metastatic Esophageal	Conc	ier		Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	-			
	LAGITITIE	<b></b>	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):				
17.	led Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
Pr.	be executed icien and burial-transit	хап	that initiated events c.  resulting in death) Last Due to (or as a consequence of):				
8760	ale be executed hysicien and the burial-transit	dical E					
687	ificate t g physical as the b	edic	<b>V</b>				
Box 6	eath certifi attending for use as	Z	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. D	ate of delive	ery
œ.	that the death certific od by the attending f detached for use as	SICIA	in the past 12 months?  1 Yes 2 No  4 Pregnant at time of death 5 Other (specify)		M	fonth	Day Year
0	at the	hys	9 Unknown				
Division of Vital Records. P.O.	w requires that s been signed b	Completed by Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		tobacco use con Yes 2 □ No		he cause of death?
or o	requir een s nould	ted		1 12			oably 4 □Unknown
ec	e law has b	ם		24a. Wa auto	s an 24b	. Were auto	ppsy findings available impletion of cause of
<u> </u>	The lav	ပွဲ		pen 1 ☐ Yes	2 No	death? 1 ☐ Yes	2 □ No
/ita	ician: Th certificate rector, pag	Be	examiner?	ath (Check only	one)		
of,	Physic this aldir	-T	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing	Home 5 ☐ Res	how injury occu		(y)
L C	ding h. After funer	For	1 □Natural 5 □ Pending (Month, Day Year) Injury Work?	280. Describe	now injury occu	ITHU	
	deat deat ctor: y the	flca	2 Accident	28f. Location	(Street and Nurr	ber or Run	al Route Number,
Š	pital or Attanding Physician: 1 ours after death. ieral Director: Atter this certifical	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		own, State)		
	To the Hospital or Attending Physicien: The law requires that the death certification 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier  (Check only   2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.	e, and due to the	cause(s) and n	nanner as s	stated.
	To the Howithin 24 To the Fu	Medical	one) and manner stated.	unou at the title			
	To To	Σ	29b. Signature and title of certifier  29c. License number	2	29d. Date sign	ed (Month,	Day, Year)
			- TANSTI		-1 W.C.	٠٦,	2006
	01		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  MYO MIN(M.D.) 9114 PHILADELPHIA ROAD #	-208	Baltim	ore.	MD 21236
	, C1	ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature			7	
	Regist		JUN 0 6 2006 July & Species				

State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6:20P M June 2, 2006 Thomas W. Meredith, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilcrest Hospice Center Catonsville Baltimore 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 78 | Yrs | Months | Days | Hours | Min. | 8. Date of Birth Manth 10ay, Year 28 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Newrytork 1 ☐ M 2 💢 F 78 Yrs. 074-24-2097 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ul Hygiene. I Hygiene. I other then "natural", or Keme 23a or 28a-f ehow ivent, tra Medical Examinar must be notified at Maryland Baltimore Halethorpe 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 5711 Mineral Ave. USA filed within 72 hours after deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give 1951 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specity: White ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be . Pages 1 and 2 should be fil tment of Health and Mental H tant: If Item 27 is marked otl lury or other treumatic ever Thomas W. Meredith, Sr. Katherine Hientz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary M. Meredith, wife 5711 Mineral Ave. Halethorpe, MD. 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Meadowridge Memorial Park 06-07-06 Elkridge, MD 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If any injury or ance. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Licenses 1328 Sulphur Spring Rd. Arbutus, MD. 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Chronic obstructing tmmediate Cause (Final PU/ monory **Physician** disease or condition years /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ner Due to (or as a consequence of): ettending physicien and for use as the burial-transit law requires that the death certificate be executed Exam that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4□Pregnant at time of death 5 Other (specify) P.O. this certificate has been signed by the all director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Dig tobacco use contribute to the cause of death? ģ Records, 1 ✓ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 \( \text{No} \) Vital 1 Tyes : After this certifical funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 At ther (Specify) 1 ☐ Yes 2 X No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Division of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of D ath 28b. Time of Certification; To the Hospital or Attending F within 24 hours efter death. To the Funeral Director: After 1 Natural 5 Pending 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JUNE 2 200C D58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST Browne no 212024 Agran J. CHARVES 31. Date filed (Month, Day, Year) 32. Reniştrar's Signature State Registrar IUN 0 6 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month MAY Physician John McGowan, Jr. 31 2006 10:10% /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center for Hospice Care 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) DEC 8 1917 Towson Baltimore Birthplece (State or Foreign Country)
\_\_\_\_\_
\_\_ 5. Social Security Number **Funeral** 1**X** M 2□ F RΙ 212-14-7786 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f ehov 1 ☐ Yes 2 X No Directo Baltimore Lutherville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Importent: If item 27 le marked other than "natural", or Iteme 23a or any Injury or other traumatic event, The Medical Examiner must be once. 21093 USA 300 W. Seminary Avenue Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white Completed by 3 Widowed 4 Divorced cHowan, Lo 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Contract Administrator Defense Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be McGowan. Sr. Christina Lewis ۴ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Esther A. McGowan - wife 300 W. Seminary Avenue, Lutherville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Chesapeake Crematory 6/2/2006 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses CAFA, Stephen D. Lohrmann, PA 8717 Green Pastures Drive, Towson, MD M00986 21286 23a. Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cardiomyo pathy Schemic **Physician** VECKS resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown 9 TUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ۵ 1 X Yes 2 □ No 3 Probably 4 Unknown povermonia Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 2 ER/Outpatient 3 DOA Mospig this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and tiple of certifier 29d. Date signed (Month, Day, Year) 29c. License number 58303 JUNE 1 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. CHARLUES MO BARTIMONE MIN 21204 6601 N. Charles S+ AARON 31. Date filed (Month, Ray, Year) 2006 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2000

			State Registrar	iviai ylaii	Cei	tificate of l	Death	R	eg. No.	UUb	1//45	
	Physici	an	1. Decedent's Name (First, Middle, Last)  Grace Catherine Majo	eran				2. Date of Dea Month	Day	9 Yeer	3. Time of Death 6:53PM	
	/Medic	al	4a. Fecility Name (If not institution, give street and num			4b. City, Town, or	Location of Death		4c. Co	ounty of Death	0.83FM	
	Examir	ier	1718 Johnson Street			Balti				N/A		
	Funeral Director		5. Social Security Number 213-73-2500 6. Sex 1 ☐ M 2 ☑ F	7. Age ( <i>In yr</i> s. 1	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey MAY 31	Yeer) 200	9. Birthple Count	ece (Stete or Foreign try) MD	
3	and w		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or La	cation			<u> </u>	10	Od. Inside City Limits	
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036	should be lied within /z nours atler death with the maryland and Mentale Hygiene. The Medical Ever marked other than "natural", or lteme 23a or 28a-f ehow umatic event, the Medical Ever mark the notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 1 Yes  3 Widowed 4 Divorced 12 Was Dece 1 Yes, Giv	ces? 2 [X]No e		Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 🔯 No	spanic Origin: (3 n, Mexican, Puert Specify:	o Rican, etc.)		Black, White, e		
ָ ה	natur ical	eted	15. Decedent's Education (Specify only highest grade completed)		(Give	ient's Usual Occupa	furing most of wor	king	16b. Kind	of Business/Ind	ustry	
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/lan	Mental Mental arked c	To B	Anthony David Majer	ran			Alysia	Rebecc	a I	Decker		
Š	permit. Pages 1 and 2 should Department of Health and Men Important: If tem 27 te marke any injury or other traumatic anges.		19a. Informant's Name/Relationship <i>(Type, Print)</i> Anthony D. Majeran – fath		<b>171</b> 8	Johnson	Street,					
ore	I of He		20a. Method of Disposition 1 ☐ Burial 2 🖔 Cremation 3 ☐ Removal from 3	State 20b. P	Place of Dispo emetery, crer	sition (Name of natory or other plac			20c. Loca	ition - City or Tov	vn, State	
Baltimore,	permit. Pages Department of Important: If it any injury or o once.		* 4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service Licensee			ce Cremato		/2006	Bel	tsville	, MD	
B	Depa Impo any in		21. Signature of Political Service Cicenses	MOO	986	Step 717 Green	hen D. L	ohrmann, s Drive;	PA	son MD	21286	
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	nsit	Examiner	Cause (Disease or injury	or as a conseq	uence of):							
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J.	ned by detac	by Ph	Part II. Other significant conditions contributing to de	ath but not res	ulting in the u	nderlying cause give	an in Part I.	23e. Did to	pacco use	contribute to the	e cause of death?	
rds	v requires been sign should be							1 🗆 Y	s 2	No 3 □ Proba	ably 4 Unknown	
Records,	has has	Completed						24a. Was a autops perform	y	prior to com death?	esy findings available apletion of cause of	
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	this aldii	ပ္	Hospital:		ER/Outpatier		4   Norsing ri	ome Seside			1	
ם י	After funer	tlon		h, Day Year)	Injury	28c. Injun Work	rai (? Yes 2 □ No	200. Describe in	ow injury o	occurred		
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7			30. Name and address of person who completed caus	e of death (Iten	23a) (Type,	Print)	1	Plat	1.101	v 3-011	MD	
×	Sta	ite.	31. Date filed (Month, Day, Year) 32.8	egistrar's Signa	DOO V	1 WULTE	SILEEI	DIMOC	K101	n Dringer	MOK 21213	
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			1. Decedent's Name (First, Middle, Last)					2. Date of D		V	3. Time of Death			
	Physici		HELEN		ſ	nacek		TINE	Day	Year 2006	1155 AM			
3	/Medi Examir		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of Death		4c. County					
	Funeral Director		THE TOHNS HOPKIN  5. Social Security Number  218–36–0079		s. last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D March	irth av. Year) 28,1939	Count	ace (State or Foreign rly) rland			
	pu ,	, ,	Usual Residence of Decedent	10-	71. T									
	urylar show	_	10a. State 10b. County	10c. C	City, Town or Lo	ocation				10	Od. Inside City Limits			
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	or 26	lre	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Count	ry?			
	73 will	100	8127 Murray Point	Road		21222			USA					
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, Item 27 is marked other than "natural", or iteme 23s or 28s-1 show other traumatic event, the Micical Examinational De notified at	by Funeral Director	11. Marital Status  1 Never Married XXMarried  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 🎎No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or N Rican, etc.)		e - America ck, White, e Whit	etc.			
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ᇳ	d be ental ked c ev	To B	Alexander John Dzi	eklinski			Beatrio	e Burl	Hancock					
2	2 should and Menials marke	-	19a. Informant's Name/Relationship (Ty		19b. Maili	ng Address (Street a	and Number or Rui	rai Route Numb	per. City or Town	State Zin	Code)			
Maryland	d 2 s th an th an trau		Michael S. Macek S	_		Murray F								
	1 and 1 Health em 27		20a. Method of Disposition			sition (Name of		Date	20c. Location -					
Baltimore,	Page nent c int: ff iry or		1 Surial 2 Cremation 3 R 4 Donation 5 Other (Specify)  21. Signature of Funeral Service License	emoval from State	cemetery, creatair Me	matory or other plac morial	Jun 20	e 5, 06	Belair,	Mary				
Ba	permit. Departn Imports eny inju		A LASA	leh	7	Name and Address Onnelly F 110 Solle	uneral H	ome Of Road	Dundalk,	P.A.	1222			
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8760,	ate be executed hysician and the burial-transit	cal Ex	resulting in death) Last	Due to (or as a conse	equence of):									
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the buttal-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3[	Ectopic pregnancy Other (specify)			23d. Dat	e of deliver	y Day Year			
	res that igned by be deta		Part II. Other significant conditions cor	tributing to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use conti	ribute to the	cause of death?			
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>	S 50	ToE	examiner?	ospital: 1 Inpatient 2[	☐ ER/Outpatier	t 3 DOA Othe	er: 4 🗌 Nursing Ho	me 5□Res	idence 6 □Oth	er (Specify)	1			
0	g Ph ter th neral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	28c. Injury Work			how injury occurr					
Division	Attending Independent of the Atternation of the funer by the funer	Certification:	1 Natural 5 Pending 2 Accident investigation	(World, Bay roar)	прогу		Yes 2 □ No							
/is	Atte	if C	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At	home, farm, sti	eet, factory, office		28f. Location	Street and Numb	er or Rural	Route Number,			
ă	afte afte	ert	4 Homicide	building, etc. (Spec	cify)			City or To	wn, State)					
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier Certifying Phys	ician: To the best of my kr	nowledne deat	h occurred at the tim	ne date and place	and due to the	causa/s) and ma	nnor as sta	ated.			
	Hos 24 h Fur stely	Jice	(Check only 2 Medical Examination)	ner: On the basis of examinand manner stated.	nation and/or in	vestigation, in my or	pinion, death occur	red at the time,	date and place, a	and due to	the cause(s)			
	thin thin mple	Medical	29b. Signature and title of certifier	and mariner stated.		29c. License	number		29d. Date signed	(Month D	lav Year			
	F.≥ E. 8													
	1		14 C			RE	5 - 00	0	JUNE	1,	2006			
1	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											
	1		JOHN APOSTOLID		MORTH	MOLF	e stre	ET B	ALTIMORE	MA	RYLAND 212			
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature									
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			. FOI	partment of Health and Mental Hy ertificate of Death	giene 2006 1774				
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of De Month JUNE	Day Year				
	/Media		FRANK ANTHONY MARCHIANO		<del></del>				
1	Examir	ner	4a. Facility Name (If not institution, give street and number) GENESIS HERITAGE CENTER	4b. City, Town, or Location of Death  BALTIMORE	4c. County of Death BALTIMORE				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	If Linder 1 Year If Under 24 Hrs R. Date of Rie	inth				
	Director		220-20-4120 12XM 2 F 78 Yrs.	Months Days Hours Min. (Month, Da SEPT.	15, 1927 MARYLAND				
	pu		Usual Residence of Decedent						
	anyla ehov	2	10a. State 10b. County 10c. City, Town or		10d. Inside City Limits 1 ☐ Yes 2 ☑ No				
	the M	Director	MD. BALTIMORE BAL'	LIMORE  101. Zip Code	10g. Citizen of What Country?				
	with Sa or	בֿו	656 48th STREET	21224	U.S.A.				
	ms 23	Funeral		3. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					
9	or ite	Ē	1 Never Married 2 Married 1 TYes 2 1 No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☒No Specify:					
5-0036	72 hours after death with the Maryland "naturel", or items 23a or 28a-1 ehow edical Examination must be multified at	d by	3 🔀 Widowed 4 □ Divorced If Yes, Give Year or Dates:	TO THE ZUZINO Specify.	Specify: WHITE				
5-(	- 2	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of working b. DO NOT use retired)	16b. Kind of Business/Industry				
2121	within ene. then	dμς	Elementary/Secondary (0-12) College (1-4or 5+)	SPATCHER	J.J. HAINES CO.				
	Hygie other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle,	L				
Maryland	permit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Importent: if item 27 is marked other then applying yor other freumatic event, the MODE.	To B	GUISEPPI MARCHIANO	FRANCESCA	CANDELA				
lary	2 should and Men ie marke eumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Ma	tiling Address (Street and Number or Rural Route Number	er, City or Town, State, Zip Code)				
	and and m 27			8 HARMONY COURT, BALTIN					
ore	ges 1 t of H if ite or otl		W Burial 2 □ Cremation 3 □ Removal from State cemetery, c	position (Name of Date rematory or other place)	20c. Location - City or Town, State				
3altimore,	t. Partmen		4 Donation 5 Other (Specify) ST. ST.  21. Signature of Funeral Service Licensee	ANISLAUS CEM. 6/8/06	BALTIMORE, MARYLAND				
Bal	Departr Import eny Inj		1 de la familia		ALTIMORE, MD. 21231				
			23a. Part1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.		Interval Between				
,	Physician		Immediate Cause (Final disease or condition resulting in death)	ASCULAR ACCIDENT	Onset and Dealin				
	/Medical Examiner		Due to (or as a consequence of):	ASCULAR ACCIDENT					
		듑	Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequence of):	V OF EDHON(1)					
	uted d ansit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	RTERY DISEAS	SE				
o,	e exected and an an and and and and and and and	Exa	Due to (or as a consequence of):	,					
8760,	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the buriat-transit	Physician/Medicai	COPROSE ATE C.	BACER					
9 X	that the death certific ed by the attending p detached for use as	/We	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery				
Вох	atter d for u	ciar	in the past 12 months?	3 □Ectopic pregnancy 5 □ Other (specify)	Month Day Year				
0	oy the	hysi	9 Unknown 9 Unknown						
ο,	w requires that been signed to should be det	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did to	obacco use contribute to the cause of death?				
Records,	en sig	led		1 🗆 '	Yes 2 No 3 Probably 4 ∏IMknown				
ecc	law ras be	Completed		24a. Was autop					
= H	iysicien: The law is certificate has b director, page 2 s	5		perfo	ormed? death?				
of Vital	Physicien: this certific	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only of Other:	one)				
ō	× .20	5.7	27. Manner of Death 28a. Date of Injury 28b. Time	ient 3 DOA   4 Nursing Home 5 Hesio	dence 6 □Other (Specify) how injury occurred				
lon	Attending r death. ector: After by the fune	tion	1 Datural 5 Pending (Month, Day Year) Injur	e of					
Division	Atternation of the party of the	III C	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f. Location (3	Street and Number or Rural Route Number,				
Ö	tal or rs efte at Dir	Certification:	Building, etc. (Specify)	Only of 100	, state				
	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier (Check only one)  1 Cartifying Physician: To the best of my knowledge, de control one)  1 Cartifying Physician: To the best of my knowledge, de control one one one of the best of my knowledge, de control one one one one of the best of my knowledge, de control one one one one of the best of my knowledge, de control one one one one of the best of my knowledge, de control one one one one of the best of my knowledge, de control one one one one of the best of my knowledge, de control one one one one one one one one one one	ath occurred at the time, date and place, and due to the investigation, in my opinion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)				
	To the within To the Comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)				
			Leviader ( July M)	0 27 188	6/5/06				
	3		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)	101 111 2122				
		10	31. Date filed (Month, Day, Year) 32. Registrar's Signature	er luc vungal	xc 191) 21222				
	Sta Regist		JUN 0 6 2806 Manage 15	Lack)					

DHMH 17 Rev 1/2001

			1 - For State Registrar	State o	f Marylar		artmen rtificate			and M	lental Hy	giene	211116	17748
г	Physici	an	Decedent's Name (First, Middle								2. Date of De Month	aath Day		3. Time of Death
4	/Medi	cal	Roland Vincent  4a. Facility Name (If not institution		mber)		4b. Citv.	Town, or	Location o	f Death	June	1 4c.	2006 County of Death	8:12 a.m.
	Examir	ier	5724 Cedella A		,		-	timo					n/a	•
já.,	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under Months		If Under 2	24 Hrs. Min.	8. Date of Bir	th Year)	9 Birth	place (State or Foreign intry)
	Director		Usual Residence of Decedent	1 📉 M 2 🗆 F	89	Yrs.					Sept. Da	30, ′	1916	
	/land		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	a-f sh	ctor	MD n/a		Bal	timore								1 X Yes 2 □ No
	or 28	Dire	10e. Street and Number				10f. Zip					10g. Cit	izen of What Cou	intry?
	s 23s	Funeral Director	5724 Cedella A		edent Ever in U	C 12 1	212		anania Osia	nin 2 /Cn	asifu Vas ar Na		S.A. 14. Race - Amen	ince la dia a
21215-0036	72 hours after death with the Maryland natural', or items 23a or 28a-1 show listel Exeminer rotest be notified at	by	11. Marital Status 1 □ Never Married 2 X Marr 3 □ Widowed 4 □ Divorced	Armed Fo	rces? 2 \_ No re		f Yes, spec	rify Cubai X	Specify:	, Puerto	ecify Yes or No Rican, etc.)	,-	Black, White	
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121	s within giene. r than "	ldw	Elementary/Secondary (0-12)	College (1	-4or 5+)			se retired,	)			TT	C A	
	filed Hygi other		12th grade 17. Father's Name (First, Middle,	Last)		Reti	rea		18. Mothe	r's Name	e (First, Middle,		S. Army	
lan	Vental	To Be	Anthony Mille	er					Nell	ie K	obers			
Maryland	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relations										r Town, State, Zij	
	f Health item 27 other tr		Eilene R. Millo	er/Spouse	20h F	5724 (			venue	-	ltimore			
Baltimore,	Pages 1 nent of h int: If ite		20a. Method of Disposition 1 X Burial 2 ☐ Cremation		State _ C	emetery, cren	natory or or	ther place			Date		cation - City or T	
Ę			4 ☐ Donation 5 ☐ Other (S)  21. Signature of Funeral Service	A service and a	Ga	rdens o	. Name an			,	-			Maryland
Ba	permit. Departin Imports any inju		1 especa	Hall					·	Mı			L Funera MD 212	
			23a. Part1. Enter the disease, or shock, or leart failure. List	complications that conty one cause on e	aused the deat								FID 212	Approximate Interval Between
d	Physician		Immediate Cause (Final disease or condition	3500	abble	ded	sol.	die	d. a	60	andi	0.0	dus	Onset and Death
1	/Medical Examiner		resulting in death)	Due to (	or as a conseq	uence of):	1		حاء				- Cary	Trap religio
4		-G	Sequentially list conditions, if any, leading to immediate	b. Due to	or as a conseq	uence of D	tre	سم	1 41	_5 e	oase			Jeans
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1-0-4	Ta 0	3	hail	1	+ .	~				410.0
o,	te be executed ysicien and ie burial-transit		resulting in death) Last	Due to (	or as a conseq	uence of):	0	( a		-31			1	gears
8760,		lical		la Eng	STO	pe	Lev	10-	l di	se	000	. C	himis	Renoe
9 x	eath certifica ettending ph I for use as ti	/Mec	IF FEMALE:	23c. If yes, out	TUNE									1yr-
P.O. Box	0 0	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live b	irth 2 ☐ Feta ant at time of d	I death 3	Ectopic pre Other (spe					2	23d. Date of deliv Month	ery Day Year
	requires that the been signed by th hould be detache	by P	Part II. Other significant condition		P. s.		nderlying ca	ause give	n in Part I.		23e. Did to	obacco u	se contribute to t	he cause of death?
ord	requi	eted	1) abece		llitu	<b>—</b>					1	Yes 2[	No 3 Prot	oably 4 donknown
al Records,	The law ate has t page 2 s	Completed	70	nsion	/								24b. Were auto prior to co death? 1 \( \sum \text{Yes}	opsy findings available impletion of cause of
Σ	Physician: This certificate all director, p	To Be	25. Was case referred to predical examiner?  1 Yes 2 No	Hospital:	npatient 2 🗆	EB/Outpation	+ 3□ DO	A Othe	r		(Check only o		G □Other (Specif	
Division of Vital	Attending Phy r death. ector: After thii by the funeral c		27. Manner of Death  1 Natural 5 Pendin 2 Accident investig	28a. Date of (Mont	of Injury h, Day Year)	28b. Time of Injury		Bc. Injury Work	at		28d. Describe h			<b>y</b> )
Divis	ist or Attendii s after death. al Director: A ad in by the fu	Certification:	3 Suicide 6 Could r 4 Homicide determ	ned 288. Place	of Injury - At hong, etc. (Specif	ome, farm, stre	eet, factory,	, office			28f. Location (S City or Tow	Street and vn, State)	d Number or Rura	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	one)	g <b>Physician</b> : To the Examiner: On the ba and mann	asis of examina	wledge, death tion and/or inv	occurred a restigation,	at the time in my op	e, date and inion, deatl	place, a	and due to the ded at the time, d	cause(s) date and	and manner as s place, and due to	tated. o the cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifier			011	29c.	License	number	_		29d. Date	signed (Month,	Day, Year)
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1	Ú		30. Name and address of person	200	or death (Item	1 23a) (Type,	rint)	Sha	D'	H	LACEL	CP 4	MY	21911
	Sta	te	31. Date filed (Month, Day, Year)	C 200C 32. F	gistrar's Signa	ture			1)(4	لايب	rne	10	v (U	01011
	Registr	ar	JUN U	D ZUUb	laser.	15. P	COCK!	•						

Physician //Medical Examiner  Physician //Medical Examiner  Physician //Medical Examiner  Physician //Medical Examiner  Physician //Medical Examiner  Physician //Medical Examiner  Physician //Medical Examiner  Physician //Medical Examiner  Physician //Medical Examiner  Physician //Medical Examiner  Physician //Medical Examiner  Physician //Medical Examiner  Physician //Medical Examiner  Physician //Medical Examiner  Physician //Medical Examiner  Physician //Medical Examiner  Physician //Medical Examiner  Population death)  Physician //Medical Examiner  Physician //Medic				1 - For State Registrar		Marylan		artment of tificate o				Reg. No.	006	-	749		
The first value of the value of	*	Physici	an									Day	Year	3. Time	of Death		
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Provided   Provided	-20	Examin	er			oer)				of Death							
The content of the	11 30%					Age (In vrs.	last birthdav)			24 Hrs.	8. Date of Birt	h					
Use State   Doc Corriv   Town or Location   Total State   Doc Corriv   Town or Location   Total State   Doc Corriv   Town or Location   Town or							* * *	Months Day	ys Hours	Min.	(Month, Da	y, Year)		ountry)	o or r oranger		
19th Milling Address (Stone and Number Control Route Number, City or Town, State, 22 Code)  Mr. James Von Schaven / partner  120 Limwood Avenue, Glen Burnie, Maryland 21061  200 Method of Dispersion  120 Limwood Avenue, Glen Burnie, Maryland 21061  201 Page of Desposition, Name of control Route (Stone)  120 Limwood Avenue, Glen Burnie, Maryland 21061  202 Limbood Avenue, Glen Burnie, Maryland 21061  203 Limbood Schaven / Chesapeake Cremation 200 Page of Desposition, Name of control Route (Stone)  120 Limbood Schaven / Chesapeake Cremation 200 Page of Desposition, Name of control Route (Stone)  21 Sponiture of Dispersion 1 Chesapeake Cremation 200 Page of Desposition, Name of Chesapeake Cremation 200 Page of Desposition, Officer Specific 200 Page of Desposition, Officer Specific 200 Page of Desposition, Name of Chesapeake Cremation 200 Page of Desposition, Name of Chesapeake Cremation 200 Page of Desposition, Officer Specific 200 Page of Desposition, Name of Chesapeake Cremation 200 Page of Desposition 200		9		Usual Residence of Decedent								,_,,,					
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Approximate of control of the superior of the	2	nd M mar	-	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	ng Address (Stre	eet and Numb	er or Rura	al Route Numbe	ar, City or To	wn, State,	Zip Code)			
Burial 2xXCremation 3   Removal from State   Chesapeake Cremation 2   State   Chesapeake Cremation 2   State   Chesapeake Cremation 2   State   Chesapeake Cremation 2   State   Chesapeake Cremation 2   State   Chesapeake Cremation 2   State   Chesapeake Cremation 3   State   Chesapeake Crematio		0555		Mr. James Von S	chaven /	partne	r 1:	20 Linw	ood Ave	enue,	Glen	Burni	e, Ma	ryland	21061		
Physician   Mideralizal Examinor   Physician   Mideralizal Examinor   Physician   Mideralizal Examinor   Physician   Mideralizal Examinor   Physician   Mideralizal Examinor   Physician   Mideralizal Examinor   Physician	ore.	of He of He fitem r oth			Removal from St		lace of Dispo emetery, crer	sition (Name of natory or other p	olace)			20c. Locati	ion - City or	Town, State			
Physician   Mideralizal Examinor   Physician   Mideralizal Examinor   Physician   Mideralizal Examinor   Physician   Mideralizal Examinor   Physician   Mideralizal Examinor   Physician   Mideralizal Examinor   Physician	Ĕ,	ment ant: h				Che	sapeak	e Crema	tion			Steve	nsvil	le, MD			
Physician Madelical Examiner  The Country of	Ball	Depart Import sny in		21. Signature of Funeral Service Li	lanure!	I MO				. 5					P.A.		
Due to (or as a consequence of):    Due to (or as a consequence of):				shock, of heart failure. List of	omplications that cause on each	used the death ch line.	h. Do not ent	er the mode of o	dying, such as	cardiac o	or respiratory ar	rest,		Interval B	etween		
Sequentially list conditions, and light of the significant conditions contributing to death but not resulting in the underlying cause given in Part I.    1				disease or condition	a. Due to (or	as alconsequ	uence of):	CCT						* /			
Due to (or as a consequence of):    TFEMALE   23b. Was deceden pregnant   1   1   1   1   1   1   1   1   1	E	Examiner		Control to the state of the state of			,-							1/2	years		
Section   Sect	/	≃	ner	cause. Enter Underlying		r as a consequ	uence of):							• • • • • • • • • • • • • • • • • • • •			
Section   Sect		and and -trans	cam	that initiated events	C		uanas att.										
Temporary   Compared to the course of the	0	ician burial	al E	,	D0 01 600	as a consequ	derice or).										
To be a solution of the control of t	587	phys phys s the			d												
To be a solution of the control of t	×	nding nding use a	n/M€									23d.	Date of del	ivery			
To be a solution of the control of t	Ď.	dealr e atte id for	Icla	in the past 12 months?	4 ☐ Pregnar	nt at time of de							Month	Day	Year		
To be a solution of the control of t	0.	by thatache	hys		9L Unknow	m 											
To be a solution of the control of t	Ś	igned igned be de	by	Part II. Other significant condition	s contributing to dea	th but not resi	ulting in the u	nderlying cause	given in Part	1.					/		
To be a solution of the control of t	p .	neduli een s	ted								1 U Y	′es 2∐N	lo 3∐Pr	obably 4	∐Unknown		
To be a solution of the control of t	ec ec	has b	nple								autop	sy .	prior to	topsy finding completion of	s available cause of		
To be a solution of the control of t	<u> </u>	r, pag												210 No			
To be a solution of the control of t	<b>=</b>	sectification in the control of the		examiner? /	Hospital:		50/0		Other								
To be a solution of the control of t	ō	r this ar this aral di					28b. Time of	IL SLI DOA	4 🗆 N					cify)			
To be a solution of the control of t	<u>o</u>	ath. T: Afte	atlor			Day Year)	Injury			No							
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of corporation of the death (Item 23a) (Type, Print)  State  31. Date filed (Month, Day, Year)  32. Jegistrar's Signature	Vis.	ar degrade by th	HC	datamia	200. Place 0	f Injury - At ho	ome, farm, str	eet, factory, office	се				umber or Ru	ıral Route Nu	ımber,		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State 31. Date filed (Month, Day, Year)  32. Jegistrar's Signature	ِ مَ	rsafte rsafte alDii	Cer		Danding	, 0.0. (0,000.)					on, or 1 on	, Glato)					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State 31. Date filed (Month, Day, Year)  32. Jegistrar's Signature	:	is nosp 124 hou is Funei letely fil	dical	(Check only 2 Medical E	xaminer: On the bas	is of examina	wledge, death tion and/or in	occurred at the vestigation, in m	e time, date ar ly opinion, dea	nd place, ath occurr	and due to the ded at the time, d	cause(s) and date and pla	d manner as ce, and due	stated. to the cause	o(s)		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State 31. Date filed (Month, Day, Year)  32. Jegistrar's Signature	:	To the comp	ĕ	29b. Signature and title of certifier	// " 4	-0						29d. Date si	gned (Monta	h, Day, Year)			
State 31. Date filled (Month, Day, Year) 32 registrar's Signature	)	,		1 Lina	Je M	U		KE	=50Q	00		6/3	5/01	5			
State 31. Date filled (Month, Day, Year) 32 registrar's Signature		10		30. Name and address bi person w	no completed cause	of death (Item	1 23a) (Type,	Print) UW au	Ba	Atr	ore,	MB	121	231			
						gistrar's Signa	ture	and a	, .		T						

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

JUN 0 6 2006

Division of Vital Records, P.O. Box 68760,

Registrar's Signature

			1 - State of Maryland / Department of Healt Certificate of Dea		Hygien Reg. N	711116	17751
	Physicia		1. Decedent's Name (First, Middle, Last) Henrietta M. Pospisil	2. Date Mont	of Death	2 2001	3. Time of Death 0 4,40 pm
9	/Medic Examin		4a. Facility Name (If not institution, give street and number)  Belav Health + Renab Center  Bela  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year   If Urder	air		c. County of Deat Hav fo 9. Birt	hplace (State or Foreign
	Funeral Director		215-01-8529 1 M 2 F 87 Yrs. Months Days Hou	ours Min. Sept	of Birth th, Day, Yea	918 Man	ryland
	ylend		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			,	10d. Inside City Limits
	he Mai 28a-1 e cuiffed	ector	Md. Harford Forest  10e. Street and Number 10f. Zip Code	t Hill	100.0	itizen of What Co	1 Tyes 2 No
	h with t	al Dir		1050	_	J.S.A.	unity :
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If then 27 is marked other than "netural", or itema 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:  13. Was Decedent of Hispania If Yes, specify Cuban, Me:  14. Was Decedent Ever in U.S. Armed Forces?  15. Was Decedent of Hispania If Yes, Specify Cuban, Me:  16. Was Decedent Ever in U.S. Armed Forces?  17. Was Decedent of Hispania If Yes, Specify Cuban, Me:  18. Was Decedent of Hispania If Yes, Specify Cuban, Me:  19. Was Decedent of Hispania If Yes, Specify Cuban, Me:  19. Was Decedent of Hispania If Yes, Specify Cuban, Me:  19. Was Decedent of Hispania If Yes, Specify Cuban, Me:  19. Was Decedent of Hispania If Yes, Specify Cuban, Me:  19. Was Decedent of Hispania If Yes, Specify Cuban, Me:  19. Was Decedent of Hispania If Yes, Specify Cuban, Me:  19. Was Decedent of Hispania If Yes, Specify Cuban, Me:  19. Was Decedent Ever in U.S. Armed Forces?  19. Was Decedent Ever in U.S. Armed Forces?  10. Was Decedent Ever in U.S. Armed Forces?  10. Was Decedent Ever in U.S. Armed Forces?  11. Was Decedent Ever in U.S. Armed Forces?  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispania If Yes, Specify Cuban, Me:  14. Was Decedent Ever in U.S. Armed Forces?  15. Was Decedent Ever in U.S. Armed Forces?  16. Was Decedent Ever in U.S. Armed Forces?  16. Was Decedent Ever in U.S. Armed Forces?  17. Was Decedent Ever in U.S. Armed Forces?  18. Was Decedent Ever in U.S. Armed Forces?  19. Was Decedent Ever in U.S. Armed Forces?  19. Was Decedent Ever in U.S. Armed Forces?  19. Was Decedent Ever in U.S. Armed Forces?  19. Was Decedent Ever in U.S. Armed Forces?  19. Was Decedent Ever in U.S. Armed Forces?  19. Was Decedent Ever in U.S. Armed Forces?  19. Was Decedent Ever in U.S. Armed Forces?  19. Was Decedent Ever in U.S. Armed Forces?  19. Was Decedent Ever in U.S. Armed Forces?  19. Was Decedent Ever in U.S. Armed Forces?  19. Was Decedent Ever in U.S. Armed Forces.  19. Was Decedent Ever in U.S. Armed Forces II U.S. Armed Forces.  19. Was Decedent	nic Origin? (Specify Yes exican, Puerto Rican, et pecify:	or No- c.)	14. Race - Ame Black, White Specify: White	e, etc.
Maryland 21215-0036	ithin 72 ho ie. ien "netur i Medical i	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12)  College (1-4or 5+)  15a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	most of working		Kind of Business	Industry
d 21	filed wi Hygien other th	e Con	8 years homemaker  17. Father's Name (First, Middle, Last) 18. M	Mother's Name (First, M			
Van	Mental Mental arked atic ev	To Be		Anna Jansky			
28	id 2 should be s		19a. Informant's Name/Relationship (Type, Print)  Norman Pospisil/son  19b. Mailing Address (Street and No. 2038 Tiffany Ter		·		
e e	es 1 ar of Hea of Hean of Item		20a. Method of Disposition 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c.	Location - City or	Town, State
Baltimore.	iit. Pag artment ortant: injury c		4 □ Donation 5 □ Qther (Specify) entombment Gardens of Faith Ce  21. Signature of Funeral Service Licensee 22. Name and Address of F		6 Ba	ltimore,	, Md.
8	Depril De		Buen a Ulle Schimunek F 610 W. MacP	Funeral Hom			Inc. 21014
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, suc shock, or heart failure. List only one cause on each line.				Approximate Interval Between Orset and Death Y/4/
8760	(cate be executed burker; transit sthe burker; transit	dical Examiner	Due to (or as a consequence of):  b. Due to (or as a consequence of):  b. Due to (or as a consequence of):  cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  c. Due to (or as a consequence of):				
	he death certif the ettending thed for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   4   Pregnant at time of death   5   Other (specify)   9   Unknown   9   Unknown   1   1   2   3   2   3   2   3   3   3   3   3			23d. Date of del Month	ivery Day Year
05p	requires that the been signed by should be detact	Ď	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in F	Part I. 23e.		1.0	the cause of death?
A P		Completed			Was an autopsy performed?	prior to death?	stopsy findings available completion of cause of
士 禁	Physician: this certific	To Be	examiner?	Place of Death Check		6 Other (See	nuffe)
rie	After une		27. Manner of Death 1 Matural 5 □ Pending (Month, Day Year) 2 Maccident investigation 28a. Date of Injury 28b. Time of Work? Injury 4 Work? 1 □ Yes	28d. Des		ury occurred	ony)
( )	7.25.0	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Loca City	tion (Street a or Town, Sta	and Number or Ru te)	ural Route Number,
	To the Hospital of within 24 hours of To the Funeral D completely filled in	edical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, dat 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.	ate and place, and due t n, death occurred at the	time, date a	s) and manner as nd place, and due	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier  D 3 44 5-2	<b>L</b>	Ma	ate signed (Monti	2006
	$\mathcal{I}$		30. Name, and address of person who completed cause of death (Item 23a) (Type, Print)	1 Air N	nary/	and ;	21014
	Sta Regist		31. Date filed (Month, Day, Year)  JUN 0 6 2006		-/		

			1 - For State Registrar	State of	Marylan		artment of H tificate of I			giene 20 (	06 17752
Ţ.	Dhusisi		1. Decedent's Name (First, Middle, Last).  2. Date of Death							3. Time of Death	
	Physici /Medio		DAVID PATTEN						JUN 6	22	106 1215 M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b.					Location of Death	1	4c. County of	Death
		~	Baltimore Washington Medical Ce 5. Social Security Number 6. Sex 7. Age (In yrs. I					rnie If Under 24 Hrs.	I 9 Date of Birth		e Arundel
L	Funeral Director		5. Social Security Number 006-46-2436	1⊠M 2□F	60	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 5-20-19	, Year) 946	9. Birthplace (State or Foreign Country) Maine
	pu &		Usual Residence of Decedent  10a, State 10b, County		10c Cib	y, Town or Lo	cation				10d. Inside City Limits
	Aaryla f •ho	or	1 □ Yes 2 № No								
	286-	rect	VA Gloucester Gloucester  10e. Street and Number 10f. Zip Co							l0g. Citizen of Wh	nat Country?
	within 72 hours after death with the Maryland ene. then natural', or items 23s or 28e-f ehow fra Madical Evantinar must be notillised at	i D	9361 Sheldon Lar	ne			23061			U.S.A.	
		Funeral Director	11. Marital Status 12. Was Decedent Ever in Armed Forces?			n U.S. 13. Was Decedent of Hispanic Origin? (Specify Section of Hispanic Origin) (Specify Cuban, Mexican, Puerto R			pecify Yes or No-	ity Yes or No- 14. Race - American Indian, ican, etc.) Black, White, etc.	
39	urs after	by Fu	1 ☐ Never Married 2X Marrie 3 ☐ Widowed 4 ☐ Divorced		2 □ No		1 ☐ Yes 2X No	Specify:	7 110411, 010.7	Specify:	white
ဝို	72 hou	ted	15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation				16b. Kind of Business/Industry	
Maryland 21215-0036	ithin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)			(Give kind of work done during most of working life. DO NOT use retired)			King		
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural; or items 23s or 28e-1 ehow any injury or other traumatic event, the Madical Examinating the notified at once.	Co	12 17. Father's Name (First, Middle, La	actl		Truck	Driver	19 Mother's Nem	o (First Middle		ing Company
and		o Be	Ernest Patten				18. Mother's Name (First, Middle, Maiden Sumame)  Maude Cox				
2		To	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							tate, Zip Code)	
			Mrs. Judith Patt	en / wife	2		Sheldon				
ore,			20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3	Communition C	1 ~	lace of Dispo	sition (Name of natory or other plac			20c. Location - C	
altimore,			4 □ Donation 5 □ Other (Spe				r Cremat		5-2006		ter Point, VA
Ball			21. Signature of Funaral Service Licenses  22. Name and Address of Facility Singleton Funeral Home, PA  1 Second Ave SW; Glen Burnie, MD 21061								
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate								
			shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  Arteriosclerotics Heart Dislass  Interval Between Onset and Death								
			resulting in death)  Due to (or as a consequence of):								
/			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (o	uenca ot):						
	acuted and transit	Examiner	Cause (Disease or injury that initiated events								
60,	icate be executed physicien and s the burial-transit	resulting in death) Last  Due to (or as a consequence of):									
58760,		n/Medical		d							
Box (	leath certifi attending p I for use as		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy								23d. Date of delivery
	death e atte	Physician/M	in the past 12 months?  1 Yes 2 No  1 Ves 2 No							Month Day Year	
<u>Р</u>	thet the de led by the a detached t	þ	9 Unknown								
Records,	Physician: The law requires that the death certif this certificate has been signed by the attending at director, page 2 should be detached for use a		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Nonown		
Ö		Completed							24a. Was a		re autopsy findings available
		mo;				-			autops perform	ned? pric	or to completion of cause of ath? ] Yes = 2□ No
Division of Vital	cian: artifica ctor,	Be	25. Was case referred to medical axaminer?								
	or Attending ifter death. Director: After in by the funer	2	1 Yes 2 No Hospital: 1 Inpatient 2 Noutpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
		tlon:	27. Manner of Death  1 Natural 5 Pending	28b. Time of Injury	28c. Injury Work	at ? /es 2 □No	28d. Describe ho	ow injury occurred			
/ISI		Ifica	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At hor			nome, farm, street, factory, office 28f. Loca			28f. Location (St	tion (Street and Number or Rural Route Number,	
5		Certification:	4 Homicide	building	building, etc. (Specify)			City or Towr	City or Town, State)		
	To the Hospitel within 24 hours a To the Funeral completely filled	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	To th within To th compl	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)								
)	. t.		/ Shilling of Jong 06054 6 13/6								
	10		Milliam Roman D06054 6/3/6  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  William R. Jones, mo 695 America 21035								
	Sta	te	31. Date filed (Month, Day, Year)	32.49	gistrar's Signat	ture	- 0	11 1 me	11-11	5/0	/3
	Registr	ar	NOW 0 6 2006 Begge & Specie								

			1 - For State Registrar	State of	Marylar	•	artmen rtificat			and M	ental Hy	giene	2006	17	753
I	Physici		1. Decedent's Name (First, Middle, La: Jean C. Palett								2. Date of Dea	ath 3 <sup>0</sup> 9	20ඊ්		of Death 5рм
}	/Medic Examin		4a. Facility Name (If not institution, giv Maplewood Park P	street and nun lace	nber)			Town, or ethe	Location o	of Death		_	County of De Contgoi		
	Funeral Director		5. Social Security Number 577-28-5793 6. S	ex □M 21X1F	7. Age (In yrs. 84	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birt	h Y 1 <sup>7</sup> 9°2'1	9. E Wa:	Shing to	or Foreign n DC
	yland		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside	City Limits
	the Mar 28e-f et notified	rector	MD Montgot	nery		Bethes	da 10f. Zip	Code				10a. Citi	zen of What		es 241 No
	ath with s 23a or	ral Di	9707 Old Georget										USA		
036	urs after de ei', or items Examiner n	by Funeral Director	11. Marital Status  1 □ Never Married 2 ♣ Married 3 □ Widowed 4 □ Divorced	12. Was Dece Armed For 1 Tyes If Yes, Giv Year or Da	ces? 2₹∰No e		Was Deced If Yes, spec 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto	cify Yes or No- Rican, etc.)		Black, W Specify: W		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if Item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, The Medical Examinar must be notified at anone.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		-4or 5+)	1	dent's Usua kind of wo DO NOT us	rk done d se retired	furing most )	of worki	ng		nd of Busines		
Maryland 2	ould be filed Mental Hygi arked other atic event, a	To Be Co	17. Father's Name (First, Middle, Last, Alfredo Guaragna								(First, Middle, Barbag	Maiden	Sumame)		
Mar	alth and 27 is m		19a. Informant's Name/Relationship ( Arthur Paletti/hi	Type, Print) 18band		19b. Mailir 970	ng Address 7 O1d	Geo	nd Numbe rgeto	wn R	d. #121	er, City or .8 B∈	Town, State thesd	. Zip Code) a., MD 20	)814
Baltimore,	Pages 1 ament of He ant: if item lury or other		20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		State Ch	Place of Dispo cemetery cre esapeal	natory Cro	emat		06-	03-2006	Вє	ltsvil	or Town, State Lle, MD	
Ball	permit Depart Import any in		21. Signature of Funeral Service Licer	unan	M003	82 22	Rapp 933	fun Gist	eraT Av S	& Cr ilve	emation r Sprin	Ser g MD	vice 2091	)	
1	icate be executed / Medical / Medica	cal Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Cere Due to ( b. Rena Due to (	ach line.	asculai quence of): ure quence of).			g, such as	cardiac o	r respiratory ar	rest,		Approxim- interval Bi Onset and	etween
P.O. Box 68	Physician: The law requires that the death certificat this certificete has been signed by the ettending phy raid director, page 2 should be detached for use as th	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ yes 25tNo 9 □ Unknown		rth 2 ☐ Feta ant at time of o	aldeath 3[	Ectopic pr Other (sp					2	3d. Date of o	lelivery Day	Year
	w requires that s been signed b should be deta		Part II. Other significant conditions of End Stage Dement		ath but not res	sulting in the u	nderlying c	ause give	en in Part I.					to the cause of	
I Records,	The law rec sete has been page 2 shou	Completed	Failure to Thrive	2							24a. Was autop perfor 1 \( \text{Yes} \)	rmed?	prior to death	autopsy findings o completion of ? es 2 \( \square\) No	s available cause of
Vital	sician: certific lirector,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	entiont 2	] ER/Outpatien	* 20 00	A Othe			(Check only o				
Division of	ding h. After fune		27. Manner of Death  1 🖾 Natural 5 🗆 Pending  2 🗀 Accident investigation	28a. Date of (Montal)		28b. Time of Injury		8c. Injury Work	at	2	ne 5 Resid			оеспу)	
Divis		Certification:	3 Suicide 6 Could not be determined	288. Place	of Injury - At h ig, etc. (Speci	ome, farm, str fy)	eet, factory	, office		2	28f. Location (S City or Tow			Rural Route Nu	m <i>ber</i> ,
	To the Hospitel or within 24 hours efte To the Funerel Dir completely filled in	edical (	29a. Certifier 1⊠ Certifying Ph (Check only one)	ysician: To the niner: On the ba and mann	sis of examina	owledge, death ation and/or in	occurred vestigation,	at the tim , in my op	e, date and inion, deat	d place, a	and due to the ded at the time, d	cause(s) date and	and manner place, and d	as stated. ue to the cause	(s)
)		Me	29b. Signature and title of certifier	1/0 m	110		290	License	number	71	-	29d. Date	signed (Mo	nth, Day, Year)	
1	D		30. Name and address of per on who					ロコ	041	1 ( n C=	nder MD	9	1.10	6	
	Sta		Merlyn K. Vemury  31. Date filed (Month, Day, Year)		gistar's Sign	ature			PITAG	r op	ring un	209	02		
- 3	Registr	ar	א ש אישוב	ע בטעט 🕨	LIKENS.	1 100	STATE OF	3							

			For State Registrar	State of M	arylar				ealth a Death	and M		giene Reg. No.2	06	17754
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last LOUISE  4a. Facility Name (If not institution, give		-	DAPA-			Location o	of Death	2. Date of Dea	Day Ol G	Year	
	Examin	er	242 RIVERVIEW AV	/Е.		last birthday)			DALK		8. Date of Birt	BA	LTIMO	ORE
	Funeral Director			М 20 Г	72	Yrs.	Months	Days	Hours	Min.	DEC. 6	, 1933	Cou	place (State or Foreign ntry) MD .
	Maryland I-f show	tor	10a. State 10b. County  MD BALTIMOR	RE	10c. Ci	y, Town or Lo DUNDAL								10d. Inside City Limits 1 ☐ Yes 2 🏧 No
	h with the 3a or 28e at be not	i Director	10e. Street and Number 242 RIVERVIEW AVI	Ξ.	•		10f. Zip	Code	212	222		10g. Citizen of UNITED		
980	72 hours after death with the Maryland "natural", or Itema 23a or 28a-f show olical Examinat must be notilied at	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces?  1 Yes 2 H If Yes, Give X Year or Dates:			Was Dece f Yes, spe		spanic Origin, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	- 14. Ra Bla Speci	ck, White,	can Indian, etc. HTE
21215-0036	within ane. than *	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 11TH	cation le <i>completed)</i> College (1-4or :	5+)	life. L	tent's Usu kind of wo DO NOT u	rk done d se retired,	uring most	t of worki	ing	16b. Kind of 8		
Maryland 2	be filed ital Hyg id other svent,	To Be C	17. Father's Name (First, Middle, Last) CHARLES WELCH						KATI	HERI	(First, Middle, NE HOUC	HEN		
	Ith ar		19a. Informant's Name/Relationship (T) LURA HOCK/DAUGHTI				•	•			UNDALK			
Baltimore,	S 4 0		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐ 6  4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		Place of Dispo Semetery, cren ETRO CR	natory or t	ther place			3, 200	20c. Location 6BALTIM		own, State MARYLAND
Balti	permit. Page Department of Important: If any injury or QDC®.		21. Signature of Funeral Service Licens	98										SON, INC. ND 21224
	Fnysician /Medical Examiner	91	23a. Part1. Enter the disease, or com- shock, or heart failure. List of o Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate	a	A N a consec	quence of):	er the mod	le of dying	, such as	cardiac (	or respiratory ar	rest,		Approximate Interval Between Onset and Death
8760,	rate be executed obysician and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consec	uence of):								
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	I death 3	]Ectopic p ] Other (s <sub>i</sub>						ate of delive	ery Day Year
ecords, P.	w requires that been signed I should be det	by	Part II. Other significant conditions co CHRONIC OBSTRUC				DISE	ause give	n in Part I.		23e. Did to	_		he cause of death? bably 4 □Unknown
$\mathbf{\alpha}$	: The law re cate has bee page 2 sho	Completed	ATRIAL FLUTTER	3							24a. Was autop perfo	sy	prior to co death?	opsy findings available impletion of cause of
f Vital	iysician: Th	To Be	25. Was case referred to medical examiner?  1 □ Yes 2 No	Hospital: 1 ☐ Inpatii	ent 2	ER/Outpatien	t 3 🗆 Do	Othe Othe			n <i>(Check only o</i> me 5 <b>⊠</b> Resid		her (Specil	fy)
ion of	ittending Phideath.		27. Manner of Death 1 → Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Inju (Month, Da	iry iy Year)	28b. Time of Injury	м	8c. Injury Work			28d. Describe h			
Division	or A after Direction by	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, et	jury - At h tc. <i>(Speci</i>	ome, farm, str	eet, factor	, office			28f. Location (5 City or Tox		ber or Rura	al Route Number,
	To the Hospital within 24 hours of To the Funeral I completely filled	Medical (	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sician: To the best iner: On the basis of and manner st	f examina	owledge, death	occurred estigation	at the tim	e, date and inion, deat	d place, th occurr	and due to the e	cause(s) and m date and place,	anner as s and due to	stated. o the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		1,			c. License				29d. Date signe		
1	0		30. Name and address of person who c	ompleted cause of	death (Iter	m 23a) (Type.	Print)	C.E.	032	R	Al Dining	OF MT	202	2006
	Sta Registi		31. Date filed (Month, Day, Year)  JUN 0 6 21	32. Figisti	ar's Sign	sture A	park	,	ILLE		ALTIMOF	1-11	, αι	uu i

		State of N  State of N  State of N  Registrar  Amend Items 26,30, p  Registrar  Amend #5 Per Inf G85  Decedent's Name (First, Middle, Last)	er verb.,6 6 6/08/06	e ilica	ale of t	yeath	)	F	Reg. No.		2 Time of Day
Physicia	an	Decedent's Name (First, Middle, Last)					2.	Month	Day	Year	3. Time of Dea
/Medic	al	Philip Cecil Rice  la. Facility Name (If not institution, give street and number	el .	4h Ci	ity, Town, or	Location		ay 21,	2006 4c. County	v of Deeth	6:15 A
Examin	er	7402 2nd Avenue	"		kesvil		51 0 0 0 111		Carr		
Funeral			Age (In yrs. last birtho	day) If Und	der 1 Year	If Under	24 Hrs. 8.	Date of Birt		9. Birth	plece (State or Fo
Funeral Director		U30-24-2313 1⊠M 2□F	75 Yr	s. Month	hs Days	Hours	Min. Se	pt 24	, Year) , 1930	New	York
D		Usuel Residence of Decedent	10c. City, Town o	ar Legation							10d. Inside City Li
anylar ahow	_	10a. State 10b. County									1 ☐ Yes 2½
be filed within 72 hours efter death with the Maryland Hygiene. Hygiene 4 other than "naturel", or iteme 23s or 28s-f ehow event, tra Medical Examirwir insat to rotified at event, tra Medical Examirwir insat to rotified at	Director	MD Queen Annes	Cheste		Zip Code				10g. Citizen of	What Cou	intry?
with the		10e. Street and Number								***************************************	21 Ki y 1
9am	erai	7 C Queen Victoria Way  11. Marital Status  12. Was Deceden	nt Ever in U.S.		21619 ecedent of H	ispanic Ori	igin? (Specify	Yes or No-	USA 14. Ra	ce - Amer	ican Indian,
le lu	Funeral	Armed Force 1 Never Married 2 Married 1 X Yes 2 [					gin? (Specify n, Puerto Ric	an, etc.)	Bla	ck, White	, etc.
o le	þ		s: 148–66	1 ☐ Yes	s 2 <b>X</b> No	Specify:			Specia	whi:	te
ical E	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. D	ecedent's U Give kind of	Jsual Occup	ation during mos	t of working		16b. Kind of E	Business/l	ndustry
Med.	pie	Elementary/Secondary (0-12) College (1-40	r 5+)	life. DO NO	T use retired	1)					
other than vent, I've Me	Son	12 4	Eng.	lish T	Геасhе		-1-31		Educat		
ed off	Be	17. Father's Name (First, Middle, Last)							Maiden Sumai		
Mental arked o	유	Philip Cecil Rice	100		(0)				n Price		in Codel
and Men is marke raumatic		19a. Informant's Name/Relationship (Type, Print)							er, City or Town		
Health and Men tem 27 is marke other traumatic		Victoria Rummell/daughter	20b. Place of D			Lover	Drive		20c. Location		MD 21042 Fown, State
nent of H ant: If iter ary or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta	cemetery	crematory o	or other place	(8)			200. 2004.0	Only of	
Departmen important:  eny injury once.		*4 ☑ Donation 5 ☐ Other (Specify)		OO Nome	a and Addres	an of Englis					
Important: If item 27 is eny injury or other tra		21. Signatur Funan Service Licensee Ronald S. Di	rector	State	e and Addre e Anat imore,	omy E MD 2	goard (	655 W.	Baltin	nore	Street
		23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	ed the death. Do no	ot enter the n	mode of dyin	g, such as	cardiac or re	espiratory as	rrest,	,	Approximate Interval Betweet Onset and Deat
hysician		Immediate Cause (Final disease or condition resulting in death)	-10/	NEW						4	12415
Medical aminer		Due to (or	as a consequence of	·):							Į.
	ē	Sequentially list conditions, b. Due to (or	as a consequence of	).							
Insit	E .	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
sician and burial-transit	Examin	resulting in death) Last Due to (or	as a consequence of	i):							
ysicia ne bur	icai	d									
attending physical for use as the b	Physician/Medi	IF FEMALE:								1	
ttend or use	an/	23b. Was decedent pregnant 1 Live birth	2 Fetal death		ic pregnancy	/				ate of deli onth	very Day Year
the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	t at time of death	2 C Other	r (specify)						
ed by the a detached t	P	Part II. Other significant conditions contributing to deat	h but not resulting in t	the underlyin	ng cause giv	en in Part	l.	23e. Did t	obacco use cor	ntribute to	the cause of deat
sign d be	d by							1,2	Yes 2□No	3 🗆 Pro	obably 4 Unk
been signed t should be det	Completed							24a. Was	an 24b.	. Were au	topsy findings ava
2 2	Ig II							autor perfo	osy ormed?_	prior to death?	completion of caus
certificate ector, pag						00.00	-151-6	1 Yes		1 🗆 Yes	2 No
	Be	25. Was case referred to medical examiner?  Hospital:	a C EBYO		Oth		e of Death (C		o <i>ne)</i> dence 6 🕅 Ot	that /Case	Son's
rthis	5.	27. Manner of Death 28a. Date of	atient 2 ER/Outp	me of	DOA 28c. Injur	y at			how injury occu		Resider
Afte	Ş	1 ☑Natural 5 ☐ Pending (Month, 2 ☐ Accident investigation	Ďa <i>ý</i> Ye <i>ar)</i> Inj	jury M	Wor 1 □	rk? Yes 2 🗀	]No				
ctor y the	Certification:	3 Suicide 6 Could not be 28e. Place of	Injury - At home, fam	m, street, fac	ctory, office		281	Location (	Street and Num	ber or Ru	ral Route Number
Dire d in b	erti	4 Homicide determined building	etc. (Specify)					City or To	wn, State)		
To the Funeral Director: After this completely filled in by the funeral di	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the business and mannel	s of examination and	death occur Vor investiga	rred at the til	me, date a opinion, dea	nd place, and ath occurred	d due to the at the time,	cause(s) and n date and place	nanner as , and due	stated. to the cause(s)
mple	Med	29b. Signature and title of certifier	stated.		29c. Licens	e number			29d. Date sign	ed (Month	h, Day, Year)
F 8		Mud fram			13	988	7		5/31/0	06	•
		30. Name and address of person who completed cause	of death (Item 23a) (I	Type Print\	01	100	11		1		
		David Smith, M.D., 29466			Eastor	n, MD	21601				
	ate		istrar's Signature								
	rar	JUN 0 6 2006	1 55 /4	DE TENSOR							
Regist		0011				·					

DHMH 17 Rev 1/2001

ORIGINAL

			1 - State of Maryland / Dep Registrar State of Maryland / Dep 4c per Dr., G856,06/6	artment of Health and filliate of Death		
	Physici		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month D	ay Year 3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and number) UNIV. MD HOSP	4b. City, Town, or Location of Dea		c. County of Death
T. T.	Funeral Director		5. Social Security Number 210-12-8408 6. Sex 1 M 2 KF 7. Age (In yrs. last birthday rs.	If Under 1 Year   If Under 24 Hrs   Months   Days   Hours   Min		9. Birthplace (State or Foreign Country) Pennsylvania
	land w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Mary a-f eh	tor	PA York	York		1 ☐ Yes 2X No
	death with the Maryland ms 23a or 28a-f ehow r must be notified at	ai Director	10e. Street and Number 1403 East 11th Avenue	10f. Zip Code 17402	10g. C	itizen of What Country?
0000	or ite	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 Wold Fyes 2 Wold Fyes, Give Year or Dates:	Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 X No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
ה ה	"natural",	eted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Giv.	edent's Usual Occupation s kind of work done during most of wo	nkina 16b. I	Kind of Business/Industry
V		Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker		At Home
2	ill Hygiene.  I Hygiene.  other than	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Na	me (First, Middle, Maide	n Sumame)
yla	Menta Menta srked	ToE	Raymond Heiland		hy Dennis	
Mai	and 2 shall all all all all all all all all all			ing Address (Street and Number or R East 11th Ave		
	permit. Pages 1 and 2 should be filed Department of Health and Mental Hy Important: if Item 27 is marked othe any injury or other treumatic event, any injury or other treumatic event, ance.		20a. Method of Disposition  1	matory or other place)	.	ocation - City or Town, State
Dalillio	permit. Departrimporta any inju			2. Name and Address of Facility E 800 Harford Ro	VANS CHAI	PEL OF MEMORIES lle,MD 21234
Ď.			23a. Part. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition and the cause of condition and the cause of condition and the cause of cause	5 NOCK		Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	CA OMITONINA	lite Oro. ID.	25 TATION / HO
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	This winds	io v kejor	117/10
	ficate be executed physicien and is the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	S + CORONARY A	on uny DIS	TOSE
,00,00	sicien burial	cai E	Due to (or as a consequence of):		,	
	tificate ig phys as the	ed	d			
	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funner Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
, co	uires that i signed by d be deta	by	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacto	use contribute to the cause of death?  No 3 □ Probably 4 □Unknown
5	w req	iete			24a. Was an	24b. Were autopsy findings available
	The la	Completed			autopsy performed? 1 ☐ Yes 2 🗷 No	prior to completion of cause of death?
	icien: certific ector,	Be	25. Was case referred to medical examiner?  Hospital: Hospital: All Parkers of Company o		ath (Check only one)	
5	Phys r this ral dii	To	1 ☐ Yes 2 No Pospital 1 It Inpatient 2 ☐ ER/Outpatient 27. Manger of Death 28a. Date of Injury 28b. Time of Death 28a. Date of Death 28a. Date of Injury 28b. Time of Death 28a. Dat		fome 5 Residence	
5	nding ath. r: Afte e fune	ation	1 Natural 5 Pending (Month, Day Year) Injury	f 28c. Injury at Work? M 1 Tyes 2 No	28d. Describe now inju	ny occurred
2 2	al or Atte s after des el Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street as City or Town, State	nd Number or Rural Route Number, e)
	To the Hospital or Attending Physicien: The law within 24 burus after death, within 24 burus after death. To the Funerel Director: Attenthis certificate has completely filled in by the funeral director, page 2	edical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place vestigation, in my opinion, death occu	e, and due to the cause(s arred at the time, date an	s) and manner as stated. d place, and due to the cause(s)
	To the To the Comp.	Me	29b. Signature and title of certifier	29c. License number		ite signed (Month, Day, Year)
	1		Carte V. Mypith	DO028111	6	11/06
5	•		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) UNIV. MD. 405P	2 747 .	
100	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	- THE HOLE		
	Registr	ar	UIN 0 6 2006			

		Flease	State of Marylan			•	_	
		1 - For State Registrar	olato of Marylan	-	ite of Death	Reg.	2000	17757
Physi	ician dical	1. Decedent's Name (First, Middle, Las Savanna	h Rol	binson		2. Date of Death	Day / Year	3. Time of Death
Exam		4a. Facility Name (If not institution, give Howard Count	street and number) y General H	tospital 4b. Cit	y, Town, or Location of Dea		4c. County of Death	1
Funera Directo		5. Social Security Number 6. Se 418-12-4052	V		ler 1 Year If Under 24 Hrs s Days Hours Min			nplace (State or Foreign untry) BAMA
faryland show	Į,	Usual Residence of Decedent  10a. State  10b. County  MAOVIAID HOWK		y, Town or Location	IA			10d. Inside City Limits 1 ☐ Yes 2 Mo
with the N a or 28a-1	Direct	10e. Street and Number	3 FOREST 1		Zip Code 211) 45	10g.	Citizen of What Con	
I.E., INCH YIGHTO Z.I.Z.I.SUOSO  1 and 2 should be filed within 72 hours after death with the Maryland f Healin and Menlar Hygiene.  1 f Healin and Menlar Hygiene.  1 f Healin and Menlar Hygiene.  1 f Healin and Menlar Hygiene.  1 f Healing Hygiene.  1 f Healing Hygiene.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 M Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, sp	edent of Hispanic Origin? (Specify Cuban, Mexican, Puel 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify:	
hin 72 hou	Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Decedent's Us (Give kind of v life. DO NOT	sual Occupation work done during most of wo use retired)	orking 16b	o. Kind of Business/l	ndustry
filed wit Hygiene other the		9TH GRADE  17. Father's Name (First, Middle, Last)		HOMEI	MAKER			mE
should be filed and Mental Hygi marked other	To Be	JOE	PORTER	?	MAT		HAR	
and 2 she saith and n 27 is my		19a. Informant's Name/Relationship (7)  MARY OWENS	3 (DAUGHTER)	6257 Hi	ss (Street and Number or R Oden Clearin			(ip Code) 21045
Page ento nt: if		20a. Method of Disposition  1  MBurial 2 Cremation 3  4 Donation 5 Other (Specify	Removal from State	Place of Disposition (Nemetery, crematory of	ame of	Date 20c	. Location - City or 1	
permit. Page Department o important: if any injury or	- SUCE	21. Signature of Funeral Service Licen		22. Name	and Address of Facility OSEPH H. BRILLY 40 N. FULTON	WON JR. A	UNERAL	HOME
Physicia		23a. ant 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	olications that caused the death	h. Do not enter the m		c or respiratory arrest,		Approximate Interval Between Onset and Death
/Medica	al	disease or condition resulting in death)	a. Due to (or as a conseq		,	njara,	(07)	
uted J Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):	acidos	9		
e be executed rsicien and burial-transit	cai Exa	resulting in death) Last	Due to (or as a consequence de Union		it trace	Tim		
A CO. sertificet. ding phy se as the	/Medic	IF FEMALE:	23c. If yes, outcome of pregna	0				
Lothe Hospital or Attending Physician: The law requires that the death certificete within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificete within 24 hours after death.  The Funner Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3□Ectopic			23d. Date of delive Month	very Day Year
quires that n signed b	ē	Part II. Other significant conditions of	ontributing to death but not resi	ulting in the underlying	cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
The law require his hes been single?	Completed	Dementi	a			24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
cian: ertifica ector,	Be	25. Was case referred to medical examiner?	Manadal		0.0	ath (Check only one)		
ng Physi ter this o	on: To	27. Manner of Death	Hospital: 1 Inpatient 2  28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 1 1 28b. Time of Injury	OOA Other: 4 Nursing I	fome 5 Residence		rfy)
DIVIDIO VICE IN THE INC. TO the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		M ome, farm, street, facto	1 ☐ Yes 2 ☐ No	28f. Location (Street City or Town, St		ral Route Number,
ospitai o hours aft unerei Di ly filled in		29a. Certifier Certifying Phy	/sician: To the best of my kno	wledge, death occurre	d at the time, date and place	a, and due to the cause	e(s) and manner as	stated.
o the H ithin 24 o the Fi	Medical	20h Signatura and title of Optidier	iner: On the basis of examina and manner stated.		On Linners sumber		Data diameter	0 1
- s + 3		30. Name and address of person who of SU 2 and Abdu	- Lan		D50870	Ju	me 3 rd	2004
2		30 Name and address of person who of SU 2an Abdu	completed cause of death (Item  5003	1 23a) (Type, Print)	l Bell Ln	· Cleri	wille "	MD 31029
Regi	State strar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture Socials				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#7 PER FH G856 6/6/06 WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Miriam 0545 05 2006 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Bel Air Harford Upper Chesapeake Medical Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Oct. 23, 1921 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min 1□M 2□F Maryland 214-14-4770 Yrs. 84 Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits Harford Forest Hill 1 ☐ Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21050 1 Colgate Drive U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ᠫ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married white 1 ☐ Yes 2 No Specify: Specify 3 ♥ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) material analyst aerospace 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Causley Gertrude Sperlein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julie Chaplin/great niece 717 Scottish Isle Drive, Abingdon, Md. 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Ocremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/2/2006 Baltimore, Md. Bavview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBRO VASCULAR ACCIDENT. Due to (or as a consequence of) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 □Ectopic pregnancy Month Year Dav 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4-Bonknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 🗆 Yes 2 N 25. Was case referred to medical examiner? 26. Place of Death Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

/Medical Examiner Ross, Mirian Mroodes40= Director: within 24 hours after To the Funeral Dire completely To the P

Physician/Medical Completed by Be Medical Certification; To

**Physician** 

/Medical

Examiner

10a. State

Md.

**Funeral** 

Director

or 28e-f ehow

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al Hygiene.

Is marked

Department of Important: If Its any Injury or o

**Physician** 

Pages 1 end 2 should be nent of Health and Mental

Director

Funeral

Completed by

Be

29b. Signature and title of certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DIRITHARA

2112 BELAIR ROAD, SUITETO, FAURTON, MD21047

31. Date filed (Month, Registrar

29a. Certifier

(Check only one)

32. Registrar's Signature

Amend item#19a,perInf,0856,6/9/06 The State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** JUNE 02, Doris M. Ramsay 2006 6:02 /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Center Towson Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 ☐ M 2 ☐ F 77 Yrs March 20 1929 Director MD 217-26-6522 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Show 10b. County r then "natural", or frems 23a or 28a-f shov the Medical Examiner must be notilited at 1 ☐ Yes 2 No Director MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12240 Roundwood Rd. #808 21093 USA death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Pages 1 and 2 should be liled within 72 hours alter ment of Heatilth and Mental Hygiene. ant: if Item 27 is marked other then "naturat", or the ury or other traumatic event, the Medical Exprints ury or other traumatic event, the Medical Exprints 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: white þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Solomon Elizabeth Salkavich 19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19c. Claude

Dr. Claude

Ramsay, (husband) 12240 Roundwood Rd. #808, Timonium, MD 21093 Baltimore, Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 6/6/06 permit. Page Department of Important: If any injury or once. Dulaney Valley Memorial Gardens Timonium, MD 21093 21. Signature of Funeral Service 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 Michael Flagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPOVOLEMIC SHOCK **Physician** /Médical Due to (or as a consequence of): Examiner GROIN/ PERITONEAL HEMORRHAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit COAGULOPATHY Due to (or as a consequence of): Box 68760. PERIPHERAL VASCULAR DISEASE Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknoy n à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, page 2 should be RESPIRATORY FAILURE 3 Probably 4 □Unknown Be Completed 1 Tes 2 No been 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? RENAL FAILURE has 2D No certificate LACTIC ACIDOSIS 1 Yes 1 🗌 Yes 21 tuneral director, 25. Was case referred to medica 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) fo the 29d. Date signed (Month, Day, Year) MO 29c. License number 29b. Signature and title of certifier 6-2-06 withrough D 31826 and D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LINTHICUM M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204 RICHARD L.

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month,

n, Day, Year)

Amend Item 19a, b per inf 8856 6-21-06 vt State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 9:56 PM Kuya1 Kober 2000 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner pkins 7. Age (In yrs. last birthday, timore (+1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. April 4, 1925 Pennsylvania 9. Birthplace (State or Foreign Social Security Number 6. Sex Funeral 1 QM 2□F Vrs 81 194-14-5784 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r then "natural", or Iteme 23a or 28e-f ehow the Modical Examiner must be notified at 1 Yes 2 No Director Erie Pennsvlvania Erie the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 16506 3063 West 24th Street by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Autoclave Elementary/Secondary (0-12) College (1-4or 5+) Sr. Vice President Engineers other 7 is marked othe treumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ John Ruyak Mary Basista 19a. Informant's Name/Relationship (Type, Print)

Jeanne Niebauer, Daughter

Rosemarie Schuster Ruyak, Wife Address Freet and Number or Rural Route Number, City or Town, State Zio Code) Health a 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ō = 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If eny Injury or once. June 5,2006 Erie, Pennsylvania Gate of Heaven 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burton Funeral Home Tana M01113 3613 W. 8th Street, Erie, PA 16505 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Samons **Physician** CELL CARCINONS /Medical Due to (or as a consequence of): Examiner FE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine or Attending Physicien: The law requires that the death certificate be executed physician and the burial-transit feilur Due to (or as a consequence of): Box 68760, Physician/Medicai attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed s peed s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed this certificate has page 1 Yes 2KIN6 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 000 Impatient Certification: To 2 ER/Outpatient 3 DOA After thi Month, Day Year) 27. Manner of Death 1 ☑Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No death. М I Director: A 2 Accident investigation 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ۽ 29b. Signature and Inter of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4127 M0 May 25, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimar ANGELA SIGHE F8516 AM 20 N. 32. Signature 31. Date filed (Month, Day, Year) State JUN 0 6 2006 Registrar

		ľ	1 - For State Registrar	State	of Mar	yland /			nt of H te of L		and M	ental Hy	giene /	2006	17761
j	Physici /Medic Examin	ai	Decedent's Name (First, Middle LEROY F     A. Facility Name (If not institution	RESTO		RAY	(NO)		, Town, or	Location o	f Death	2. Date of De. Month JUNE	· Bay	Year 2006 ounty of Death	3. Time of Death
	Funeral Director		Northwest # 5. Social Security Number 578-30-8829	OSPITAL 6. SOX DEM 20 F	Center 7. Age (1	In yrs. last t 83	oirthday) Yrs.	If Und Months	inda er 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bird (Month, Da	th	3 NC	-1 (Canan F
	deeth with the Maryland ms 23a or 28a-f ehow r must be notified at	ctor	Usual Residence of Decedent  10a. State 10b. County  MD Balt:	imore Ci		Oc. City, To									10d. Inside City Limits
	th with th	Funeral Director	10e. Street and Number 5607 Plymouth 3	Road					ip Code 1214				10g. Citize USA	n of What Cou	ntry?
_	be filed within 72 hours after deeth with the Marylan lat Hygiene. Ital Hygiene. do other then "netural", or Items 23a or 28a-f ehow event, the Madical Examinar must be notified at	Ď	11. Marital Status  1. Average Married 2 Married 3 Widowed 4 Divorced	Armed	ecedent Eve Forces? s 22 No Give Dates:	er in U.S.	11	f Yes, sp	edent of His ecify Cubar 2200	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto I	ecify Yes or No Rican, etc.)		Race - Ameri Black, White, pecify: Whi	etc.
	filed within 72 ha Hygiene. Ither then "netu Int, the Madical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0·12) 12	t grade complete	d) (1-4or 5+)		(Give	kind of w	ual Occupa ork done d use retired) rked	lurina most	of workin	ng	16b. Kind N/A	of Business/In	dustry
<u>D</u>		To Be C	17. Father's Name (First, Middle, Leroy Preston 1		r.						r's Name abet	(First, Middle, h Powel		итате)	
	27 15 27 14			nip (Type, Print) Niece			5607	Pl	mouth	nd Number 1 Road	d Bal	/Route Numbe ltimore	, MD	21214	
E O	Page nent o ant: If ury or		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation  4 ☐ Donation 5 ☐ Other (S)	pecify)			егу, сгеп	natory or	ame of other place remat			ປື້ນກ 5 2006	_	sville,	own, State Maryland
g C	Departit. Departr Importi eny inj		21. Signature of Funeral Service   23a. Part1. Enter the disease, or	Miller	401	143	8	3717	Green	Pastu	ires		Baltim	-	ryland 21286
<i>'</i>	death certificate be executed  Example of the period of th	dical Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially flet conditions if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. Athe Due to c.	o (or as a c	onsequence	e of):					ILAR.		HE	Interval Between Onset and Death
j.	the death certific y the attending p Iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No		e birth 2 ( gnant at tim	☐Fetal dea		Ectopic Other (	pregnancy pecify)				236	d. Date of delive Month	ery Day Year
ecords, P	The law requires that ste has been signed b age 2 should be deta	<u>۾</u>	Part II. Other significant condition  ANEMIA	ns contributing to	death but r	not resulting	in the ur	nderlying	cause give	n in Part I.			bacco use		he cause of death?
		Completed	REWRIEN	T Gas	TROI	NTES	TIN	IAL	BLE	EED		24a. Was autop perfor 1 \sum Yes	an 2 sy med <sup>2</sup> 2 2 No	24b. Were auto prior to co death? 1 ☐ Yes	opsy findings available mpletion of cause of
on of Vital	ding Physicien: T h. After this certificet funeral director, pa	tion: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pendin  2 Accident investig	28a. Dai (Mo	Inpatient e of Injury onth, Day Y	2 DER/C 28b ear)	Outpatient Time of Injury	3 _ C	28c. Injury Work	r: 4 □ Nur	rsing Hon	(Check only on ne 5 ☐ Resid 28d. Describe h	lence 6		y)
DIVISION	Hospitel or Attending 4 hours effer death. Funerel Director: After tely filled in by the funer	Certification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide determi	ot bo	ce of Injury Iding, etc. (	· At home, Specify)	farm, stre					28f. Location (S City or Tow		Number or Rura	al Route Number,
	To the Hospitel within 24 hours e To the Funerel I completely filled	Medicai (	29a. Certifier 1 Certifyin (Check only one)	g Physician: To t Examiner: On the and ma	he best of n basis of ex anner stated	amination a	ge, death and/or inv	occurre	d at the time n, in my op	e, date and inion, deati	d place, a	and due to the o	cause(s) and date and pl	nd manner as s ace, and due to	tated. o the cause(s)
	To the To the Complet	2	29b. Signature and the of certifier	ter, Mi	0			2	DOO:		41			signed (Month,	
2	1		30. Name and address of person of the Carte	who completed ca	use of deat	h (Item 23a	(Type, I	Print)	LOAZ	> K	-+n	dallst	رمد	MD2	4133
	Sta Registr	_	31. Date filed (Month, Day, Year)	100	Registrar's	Signature	do	de							

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed The law requires that the death cartificate be executed to the law requires that the death cartificate be executed to the law requires that the death cartificate be executed to the law requires that the death cartificate that the law requires that the death cartificate that the law requires that the death cartificate that the law requires that the law requires that the death cartificate that the law requires the law requires that the law requires the law requires the law requires that the law requires the law requires the law requires th	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours a Department of Health and Martal Hydiana
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certificate		Phy /M Exa
1		To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.
	1	U

	1 - State Registrar		artment of Health and rtificate of Death	Reg. No.	2000 17102
sician edical	1. Decedent's Name (First, Middle, Last)  James Edward Southe	rn,Jr.		2. Date of Death  Month  Day  June 02,	Year 2006 3. Time of Death
niner	4a. Facility Name (If not institution, give st 24 Hillside Ave.  5. Social Security Number 6. Sex	reet and number)  7. Age (In yrs. last birthday)	4b. City, Town, or Location of Dea  Cockeysville  If Under 1 Year   If Under 24 Hrs	E	County of Death  Baltimore County  9. Birthplace (State or Foreign
ral or	323-18-4103 Usual Residence of Decedent	M 2□F 86 Yrs.	Months Days Hours Min		20 Cicero, Illinoi
ector	Maryland Baltimore	e County Cockeys	sville		10d. Inside City Limits 1 ☐ Yes 2 ️ No
Funeral Director	10e. Street and Number 24 Hillside Ave.		10f. Zip Code 21030		zen of What Country? Inited States
by Fune	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces? 1 □Yes 2 XNo	Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Puei 1 ☐ Yes 2 ☑ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12) 1.2	Completed) (Give life.	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	orking	nd of Business/Industry
To Be Co	17. Father's Name (First, Middle, Last)  James Edward South	n/a ern,Sr.		me (First, Middle, Maiden ean Beyers	Jood Products Sumame)
олсе. To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type Miss Donna M. South 20a. Method of Disposition 1 □ Burial 2 20 Cremation 3 □ Re	ern (Daughter) 24 H.		keysville, M	
once	4 Donation 5 Other (Specify)  21. Signature 1 Funeral Service Licente	Greenmour	2. Name and Address of Facility		timore,Maryland remation Ctr.,P.A land 21093
ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequence of):  A ST H MA  Due to (or as a consequence of):  Due to (or as a consequence of):	7 FAILUR	e	80 YR
Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	_	□Ectopic pregnancy □ Other (specify)	2	23d. Date of delivery Month Day Year
by	Part II. Other significant conditions cont	ibuting to death but not resulting in the u	inderlying cause given in Part I.		se contribute to the cause of death?  No 3 Probably 4 Unknown
Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
Medical Certification: To Be Comp	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2  Accident investigation	spital: 1 Inpatient 2 ER/Outpatier 28a. Date of Injury (Month, Day Year) 28b. Time o	nt 3 DOA Other: 4 Nursing I	ath (Check only one)  Home 5 Residence 6  28d. Describe how injury	
Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	<i>'</i>	City or Town, State)	
Medical	29a. Certifier   Gentifying Physic (Check only one)   2   Medical Examina   2   Medical	cian: To the best of my knowledge, deat ir: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occ	urred at the time, date and	place, and due to the cause(s)
₹	. / %			0 .	1 .
Me	30. Name and address of person who com	pleted cause of death (Item 23a) (Type, 832P 6	M 1000255	30 61	16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amen item#10b-c, per H 0856 Amen Thepartment of Health and Mental Hygiene 0 0 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** STEPHEN ANDRA SAVAGE 2006 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Age (In vs. last birthday) If Under 24 Hrs. 6. Sex Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X**M 2□F 215-58-2735 Director MARYLAND Usual Residence of Decedent 10c. City, Town or Location Edgewood with the Maryland 10d. Inside City Limits 10a. State 10b. County or 28a-f show Harford other traumatic event, the Medical Examinar must be notified at 1X Yes 2 □ No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itema 23a 642 LONG 21040 USA WOOD Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 D No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Tes 2 No Specify: BLACK 3 □ Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. BETHLEHAM Elementary/Secondary (0-12) College (1-4or 5+) WELDER 12 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be f and Mental H GLADYS HAMPTON SAVAGE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health MALITA CHERELL SAVAGE 642 LONGWOOD CT EDGEWOOD, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State pernit. Pages Department of Importent: If It any Injury or o 1 ☐ Burial 2 Cremation 3 ☐ Removal from State GREENMOUNT CREMMERY JUN 03,06 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee R. Name and Address B. dity 215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably b. Were autopsy findings available prior to completion of cause of death? autopsy 2 No 1 Yes 2 No 1 ☐ Yes 25. Was case referred t examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 ther (S 1 Tes 27K 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death to the Funeral Director: 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determi ed 4 \( \text{Homicide} \) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Pay, Year) leted cause of death (Item 23a) (Type 32. Digistrar's Signature 31. Date filed (Month, Day, State Registrar

State of Maryland / Department of Health and Mental Hygiene 0 6 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Month 2006 **Physician** 4:38 A M Leslie Walter Sables /Medical 4b. City, Town, or Location of Death 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number) Examiner Center Saint Joseph Medical Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 4, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1**X**M 2□F 019-26-7255 Massachusetts Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show traumatic avent, it a Medical Examiner must be nutified at 1 XYes 2 □ No Director Florida Brevard Rockledge 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 32955 2243 Brightwood Circle U.S.A. or iteme 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours after c Deperment of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or iten any injury or other traumatic avent, it a Medical Examination. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Auto/Truck 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John A. Sables Betty G. Angell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) Dolores R. Sables 2243 Brightwood Circle, Rockledge, FL 32955 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 6/1706 1 Burial 2 Ocremation 3 Removal from State Attleboro, MA North Purchase Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ucens e <sup>2</sup>Chame and Address of Facility Chesmore Funeral Home 57 Hatden Rowe St., Hopkinton, MA 01748 Zu Mucu Approximate Interval Between Onset and Death IMMED 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEVERE LEFT VENTRICULAR FAILURE Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): AND CARDIAC ARREST Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ettending physicien and I for use as the burial-transIt 5 HOURS MYOCARDIAL INFARCTION that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, YEAR ISCHEMIC HEART DISEASE Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the e 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1X Yes 2 No 3 Probably 4 Unknown SEVERE ATHEROSCLEROSIS peeu SEVERE PERIPHERAL VASCULAR DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed? 1 Yes 2**X** No 1 Tyes 2**∑** No 24 hours after death.

Funerel Director: After this certific etcly filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 🕅 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Hospital or Attending 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai To the Hosp within 24 ho To the Fune completely fi and manner stated 29d. ate signed (Month, Day, Year) 29c. License number 29b. Signature a D40312 se of death (Item 23a) (Type, Print) 30. Na x and address o 7505 OSLER DRIVE #410 TOWSON MARYLAND 21204 JOHN C. LASCHINGER . D. 31. Date filed (Month, Day 32. Signature State Registrar

			- ru	partment of Health and Mertificate of Death	lental Hygie	7000 11100
	Physici	an	1. Decedent's Name (First, Middle, Last) Bettie, L. Sherman		2. Date of Death Month	Day Year 3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	06 02	2 2006 7:00a. <sup>M</sup> 4c. County of Death
	Exami	E	2307 N. Rosedale Street	Baltimore		n/a
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 10 M 20 F 59 Yrs.	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y) 10-28	9. Birthplace (State or Foreign Country) 1–46 N. Carolina
	land ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or			10d. Inside City Limits
	e Mary	ctor	Md n/a Balti	nore		1½ Yes 2 □ No
	23a or 26	Funeral Director	2307 N. Rosedale Street	10f. Zip Code 21216		Citizen of What Country?
5-0036	be filed within 72 hours after death with the Maryland that Hygiene. Id other then "natural", or iteme 23a or 28a-f ehow event, the Medical Examinar must be notified at	À	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married In Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spin If Yes, specify Cuban, Mexican, Puerto     □ Yes	ecity Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: African - American
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<u> </u>	2 should be and Mental le marked o	To	Willie Stowe		Steven	
Maryland 2121	d 2 sh th and th and 7 le m traum		19a. Informant's Name/Relationship (Type, Print)  19b. Ma  Tammie N. Caffee/ Daughter 351	G Voctor Pd Re		
ē,	s 1 and the life m 2 other		20a. Method of Disposition 20b. Place of Dis	position (Name of rematory or other place)		c. Location - City or Town, State
Baltimore,	Page ment c ant: If ury or		4 Donation 5 Other (Specify) Garriso	n Forest 6/7/		rings Mills, Md
Balt	permit. Pages 1 and 2 should by Depermit of Health and Menta Important: If Item 27 is marked eny injury or other traumatic engo.			22. Name and Address of Facility Wy]		PA of Balto. Co. llstown, Md 21133
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	Physician	1	Immediate Cause (Final disease or condition me tastatic	Lung Carcin	roma	Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	J		
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	To the within 2. To the f	Mec	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month, Day, Year)
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ή	)		30. Name and address of person who completed cause of d ath (Item 23a) (Typ  Murc Scholuw MD 120 Sister	Preme Dr. #105	- Towson	UMD 21204
	St	ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature	, The second		
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		1 - For State Registrar	State of Maryland / Dep		nental Hygie	•	1776
		1. Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
Physici		Nanie Ruth St	everson		May 19,	Day Year 2006	11:57 P™
/Medic		4a. Facility Name (If not institution, give s	street and number)	4b. City, Town, or Location of Death		4c. County of Death	<del></del>
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Funeral		Social Security Number     6. Sex	IM ONE	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, )	(ear) 9. Birthi	place (State or Foreign
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and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation		1.	10d. Inside City Limits
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3a or	0	7700 Cherry Lane		20707		U.S.A.	,.
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or its	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give	1 ☐ Yes 2 ☒ No Specify:	Hican, etc.)	Black, White,	
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Pages Pages nent of int: If it iry or o		14∑ Burial 2 ☐ Cremation 3 ☐ Ri 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ill Cemetery   5/27	7/06 C1	napel Hill,	, NC
Balti permit. Departn imports eny inju		21. Signature of Funeral Service License	200	2. Name and Address of Facility Burthey Funeral Se	ruico		
<b>o</b> 88558		Lennis Fr	Uneu	1510 Fayetteville	St., Durl	nam, NC 277	707
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To tl To tl	Σ	29b. Signature and title of certifier	2 / - / -	29c. License number	29d	Date signed (Month)	Day, Year)
		1 Today (	MD	142500		1/25/0	6
3		30. Name and address of person who con	mpleted cause of death (Item 23a) (Type, A) + Child Y 5632	Sille piles	Blac	ens Buy	20710
Sta Registr		31. Datě filed (Month, Day, Year)  JUN 0 6 201	oz. Mistiai a digitappia	book	•		

		FOI	of Maryland / D	•		ental Hygie	ne	17760
		State Registrar	(	Certificate of	f Death		NOC UUD	1/100
Physicia		I. Decedent's Name (First, Middle, Last)  MARCARET 5	CHREINE	=R		2. Date of Death  Month  L	Jayth 2006	3. Time of Death 5: 40 PM
/Medic Examine Funeral Director		A Facility Name (If not institution, give street and of Battimaks Washing Social Security Number 6. Sex	number)  Or for) MEdic  7. Age (In yrs. last birth	al CENTER		8. Date of Birth	4c. County of Death	lace (State or Foreign
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n with the last or 28a.	Funeral Director	10e. Street and Number 867 Woods RD	Ellinon	10f. Zip Code	122	10g.	Citizen of What Coun	try?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or items 23a or 28a-f show eny injury or other traumatic event, the Madical Examinar must be notified at once.	by Funera	1 Never Married 2 Married 1 Yes	ecedent Ever in U.S. Forces? s 2 2 00 Give	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Speuban, Mexican, Puerto l	city Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	etc.
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Maryland d 2 should be file th and Mental Hy 27 le marked oth traumatic event	10	19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (Stre	HNNA C	I Route Number, Co	NER ity or Town, State, Zip	Code)
Ore, M	1	ATHERINE LUCCA,  20a. Method of Disposition  1  Burial 2 Ocremation 3 Removal fro		Disposition (Name of c, crematory or other p		ate 200	P-Z1122 Location - City or To	
Baltimore, permit. Pages 1 at Depertment of Hea Important: If Item any injury or othe ones.		4 Donation 5 Dother (Specify) 21. Signatur A Funeru S-vice Lib nsee	ANATOM	22. Name and do	STAY 6-5 Iress of Facility y Family Funeral Ho	me And Cremation	MOVER, IL	10.
Physician		23 Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of immediate Cause (Final disease or condition resulting in death)	Caused the death. Do no	26	01 Mountain Road	Pasadena, MD	21122	Approximate Interval Between Onset and Death
Wedical Examiner only sicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	to (or as a consequence) of to (or as a consequence of to (or as a consequence of	n:				
Records, P.O. Box 68760, The law requires that the death certificate be executed has been signed by the attending physicien and page 2 should be detached for use as the burial-trans	Physician/Medical	in the past 12 months?	outcome of pregnancy e birth 2  Fetal death gnant at time of death known	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	ncy		23d. Date of delive Month	ry Day Year
ecords, P. law requires that as been signed b	δ	Part II. Other significant conditions contributing to	death but not resulting in	3 5 - 6	given in Part I.	1 ☐ Yes	/-	ably 4 □Unknown
	e Completed	25. Was case referred to medical			26. Place of Death	24a. Was an autopsy performed 1 Yes 2 Check only one	24b. Were autop prior to con death? No 1 \( \subseteq \text{Yes} \)	osy findings available inpletion of cause of
	To B	examiner? 1 ☐ Yes 2 ☐ Hospital:	Anpatient 2 ER/Out		other: 4 🗆 Nursing Hor	ne 5 ☐ Residence	e 6 Other (Specify	)
Sion sath.	ation	2 Accident investigation	te of Injury onth, Day Year) 28b. Ti	jury W	ury at ork? □ Yes 2 □ No	28d. Describe how i	njury occurred	
Division of  To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not be 4 Homicide determined 28e. Pla	ice of Injury - At home, fari ilding, etc. (Specify)	m, street, factory, offic	е 2	28f. Location (Stree City or Town, S	t and Number or Rural tate)	Route Number,
• Hosp • 24 hou • Fune letely fil	Medical	29a. Certifier (Check only one) 15 Certifying Physician: To 2 Medical Examiner: On the and m.	the best of my knowledge, b basis of examination and anner stated.	death occurred at the or investigation, in my	time, date and place, a opinion, death occurre	and due to the cause ad at the time, date	e(s) and manner as sta and place, and due to	ited. the cause(s)
To th within comp	Me	29b. Signature and title of centifier	1 mj	1	F8006	1	Date signed (Month, D	•
		30. Name and address of person who completed car Kuf: Buntly 301	Hasp.fal	Type, Print)  DRIVE	Glen Bur	Nie N	v	
Sta Registr		31. Date filed (Month, Day, Yeldr) 32  JUN 0 6 2006	. Registrar's Signature	Houll .		•		
DHMH 17 Rev 1/20	001		OR	IGINAL				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June Dav Year **Physician** 8:45 P. M Jean Antoinette Smith 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 204 Charles Street Baltimore Anne Arundel 8. Date of Birth
(Month, Day, Year)
Sept. 21,1923 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Min. Months Days 1 M 2 XF 82 Yrs 216 12 9542 Director Maryland Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits in then "natural", or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2X No Marvland Anne Arundel Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. 204 Charles Street 21225 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 ☐ Yes 2 🔼 No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Oecedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Important: if item 27 is marked other then 'eny injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Accountant / Owner Insurance / Realty 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen Kolodjieski John Rutkowski 19a. Informant's Name/Refationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean H. Smith / Daughter 204 Charles Street Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Baltimore, Maryland Holv Cross Cemeterv 6/5/2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the reath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** munths una ceunce /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death signed by the at a be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Onknown been si Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? rlospus. 24 hours aller deans. a Funeral Director: After this census. a funeral director, pr 1 Yes 2 No 25. Was case referred to medicaf examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 6 Residence 6 Other (Specify) Certification; To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified DOS7936 06-02-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
HOUTHY D. MUNNULL W 900 CONTO AVE BAHMURE, MAD 21209 Heather D. Manuel 31. Date filed (Month, Day, Year) 32. Sgistrar's Signature State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death John Wayne Shaffer 17:30 M MAY 2006 11 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BATIMOPE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 24, 15 SINAI HOSPITAL OF BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **X**M 2□ F 219-30-2296 Yrs. 1934 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XXYes 2 □ No N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3970 Falls Road 2nd Floor 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XXIII Specify: 3 ☐ Widowed 4 ₩ ivorced Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Worker Carlisle Apartments unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Wilbur Shaffer (unknown) June 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Edwards Cousin 3203 Taylor Avenue Baltimore, Maryland 21234

22. Name and Address of Facility

20c. Location - City or Town, State

Catonsville, MD

29d. Date signed (Month, Day, Year)

MAY 11, 2006

21211

6/1/2006

Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland

Physician /Medical

**Physician** 

/Medical

10a State

Examiner

**Funeral** 

Director

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: if item 27 is marked other than "naturel", or items 23s or 28s-f show or other treumatic event, the Modical Examinar must be multified at

Be

20a. Method of Disposition

21. Signature of Funeral Service Licenses

4 Donation

1 ☐ Burial 2 X Cremation 3 ☐ Removal from State

5, ☐ Other (Specify)

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23 Part En er the dise set, or complication, the t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, since, or heart failure. It is tonly one cause of neach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) pneumonia Due to (or as a consequence of): END STAGE RENAL DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month 4 Pregnant at time of death Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHRONIC OBSTRUCTIVE pulmonary disease 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? CONGESTIVE HEART FAILURE HYPERTENSION
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 1 Yes 2 No 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number

RES- 000

20b. Place of Disposition (Name of cemetery, crematory or other place)

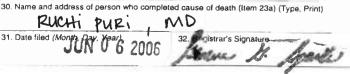
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State Registrar

DHMH 17 Rev 1/2001

PURI 31. Date filed (Month, Day, 0°6 2006

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#18,perFf\_0356,6/6/06 TF State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4, Day 2006 **Physician** June 7:03 PM Eutiquio Sanz Gutierrez /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
| Hours | Min. | Month, Day, Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral №** M 2□F Months Yrs. 66 Director March 14,1940 216-02-0576 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits rei', or items 23s or 28s-f ehow Examiner must be notified at 1 X Yes 2 ☐ No Director Baltimore City MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) United States
14. Race - American Inc
Black, White, etc. Funera 255 Waxter Way 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 √No Specify: Specify: White 2 3 Widowed 4 Divorced "naturel" Completed is marked other then "nature oumstic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Chef Restaurant 12 18, Mother's Name (First, Middle, Maiden Sumame) Emiliana Gutierrez Sanz Carmen Leon Conzalez 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Heelth and Mental ဥ Lorenzo Sanz Gutierrez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Depertment of Heelth ar
Important: If Item 27 is
eny injury or other treu Carmen Sanz, Wife 255 Waxter Way, Baltimore, MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mausoleum June 6, 2006 Timonium, Maryland 4 □ Donation 5 🛭 Other (Specify) Entantanent 22. Name and Address of Facility Brian T. Chisholm Funeral Services of 21. Signature of Funeral Service Licensee Stamon Dulaney Valley, P.A. 200 Padonia Rd. Timonium, MD 21093 M01113 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death ANGIOCATCINOMA **Physician** months /Medical Due to (or as a consequence of) Examiner S uential list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical ettending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month 4☐ Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No has page 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical 26. Place of Death | Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Anatural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director; completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the t 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) June 5, 2006 1)25205 MO ompleted cause of death (Item 23a) (Type, Print) N. Charles St. Balto . ind 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 11 per wife 9861 11-22-06 vt State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Year MAY 13, 2006 3:00  $A^{M}$ AT.VTN SAMUELS. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES HEARTLAND HEALTHCARE OF HYATTSVILLE HYATTSVILLE If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** 12 M 2□ F Yrs. JAMAICA Director 68 **JANUARY 4, 1938** 577-11-3536 Usual Residence of Decedent 10c. City, Town or Location show 10a. State 10d. Inside City Limits rthan "natural", or Itams 23a or 28a-f shov tre Medical Examinar must be notified at 1 □Yes 2 ☑ No MARYLAND PRINCE GEORGES HYATTSVILLE Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2104 WOODBERRY STREET 20782 U.S.A. death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. þ 3 □ Widowed 4 □ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 PLUMBER PRIVATE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ages 1 and 2 should be fill nt of Health and Mental H Be SAMUELS MELITA MORRISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2104 WOODBERRY STREET, HYATTSVILLE, MARYLAND 20782 MAXINE SAMUELS/DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of He
Important: If iter
any injury or oth 1 XBurial 2 Cremation 3 Removal from State '4 □ Donation 5 □ Other (Specify) GATE OF HEAVEN CEMETERY 105/20/2006 SILVER SPRING, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE, SILVER PSRING, MARYLAND 20904 23a. Part1. Enter the disease, or complications that caused the Jeath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARDIOMYOPATHY ) I MIS FLU 21/10/01 **Physician** /Medical Due to (or as a consequence of): **Examiner** THINRE END STAN CONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine -transit The law requires that the death certificate be executed ESPINATORY and physician ar s the burial-to Due to (or as a consequence of) Box 68760, Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) o. the 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ ICI DING Y 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ANA EM IA 24a. Was an autopsy performed? Yes 2 No 1 🗆 Yes 2□ No 1 ☐ Yes 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 - Nutrising Home 5 - Residence 6 - Other (Specify) 1 ☐ Yes 2 🖸 🕶 this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: or Attending 1 Anatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire Hospital 1 🖳 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0063658 Wishon MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ICRILITY AN, 4203 QUEENSBURY ROAD, HYATTSVILLE, MARYLAND 20781 DR. HARINIDEVI 31. Date filed (Month, Day Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

	1	For State Registrar		State of	Maryla				lealth a Death		ental Hy	giene, Reg. No.	200	6	17773
Physician /Medical		1. Decedent's Name (First, Mid Ellen S. Sho		)							2. Date of De	3 <del>0</del> 9	200ზ	ar	3. Time of Death 11:05p м
Examiner	_	4a. Facility Name (If not institute 3513 Raymond	on, give	street and num	iber)				Chas		-	4c. (	County of D Mont		ery
Funeral Director		5. Social Security Number 362-38-2154	6. Set	M 2⊠F	7. Age (In yrs	s. last birthday) Yrs.	If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da 02-11-	h y. Year) -1937		Counti	ce (State or Foreign y) sylvania
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aryla shov			y tgom	orv	100. 0	Chevy								10	d. Inside City Limits  1 Yes 2 No
28a-f						Onevy						10 000			
th with the 23a or 2	2	10e. Street and Number 3513 Raymond	St.				10f. Zij	Code	20815	i		US. Citiz	en of What A	Count	<b>y</b> ?
nore, Maryland 21215-0036 gas 1 and 2 should be filed within 72 hours after deeth with the Maryland to fleeth and Mental Hygiane. To fleeth fire 271s marked other than "natural; or items 23a or 28a-f show or other treumatic event, the Medical Examinar must be notified at To Re Completed by Funeral Director.	200	11. Marital Status 1 □ Never Married 2 ② Ma 3 □ Widowed 4 □ Divorce	rried	12. Was Dece Armed For 1 ☐ Yes If Yes, Give Year or Da	ces? 2¥∑No		Was Dece If Yes, spe 1  Yes	cify Cuba	ispanic Ori in, Mexican Specify:	gin? (Spe 1, Puerto I	cify Yes or No- Rican, etc.)		4. Race - A Black, W Specify: W	hite, et	tc.
Maryland 21215-0036 d 2 should be filed within 72 hours aft tin and Mental Hygiane. 77 is marked other than "natural; or treumatic event, the Medical Examitreumatic avent, the Medical Examitreumatic avent, the Medical Examitreumatic avent, the Medical Examitreum To Re Commissed by F		15. Decede (Specify only high Elementary/Secondary (0-12)	est grad	cation e completed) College (1-	4or 5+)		dent's Usu kind of wo DO NOT u	rk done d se retired	ation during mos I)	t of workir	ng	Fair		sing	stry Council Mashington
be filed tal Hygi d other event, I	9	17. Father's Name (First, Middle		<b>_</b>		DII	ecto.				(First, Middle,	Maiden S			
Ylai nould b i Ments narked		H. Frank Shrew									Daughe:				
and 2 st eith and 27 is n		19a. Informant's Name/Relation Robert Shogan/	hust	and		35 1 3	Rayr	nond	St. (	chevy	Route Number Chase	MD 2	Town, State 20815	e, Zip C	Code)
Baltimore, Maryland 2121 permit. Peges 1 and 2 should be filed within Department of Heelth and Mental Hygiane. Important: If Item 27 is marked other than any injury or other treumatic event, tracks once. To Re Compi	1	20a. Method of Disposition 1 ☐ Burial 2 🏝 Cremation 4 ☐ Donation 5 ☐ Other		lemoval from S	tota .	Place of Dispo cemetery, crea hesapea	natory or c	ther plac	ory		ate 05-2006		ation - City		
Balt permit. Depart Import any Inji		21. Signature of Funeral Service	011	mauu	M003	38Z 2	Rapp 933	Fune Fune	ral Av S	Cre ilver	mation Spring	Serv S MD	ice 20910		
Physician /Medical		23a. Part1. Ent  the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	or complist only or	Perito	ich line.	Carcino			g, such as	cardiac o	r respiratory ar	rest,			Approximate interval Between Chiset and Death Years
760, s be executed sicien and burial-transit		Sequentially list conditions, and they, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<b>\</b>	Due to (a	or as a conse										
18760, cate be extended by sicien at the burial-				j										+ -	
death certific	1	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	2		th 2 ☐ Fet int at time of	al death 3	]Ectopic p ] Other (sp					23	3d. Date of o	,	, ay Year
S, res the igner be o	3	Part II. Other significant condi	tions cor	ntributing to dea	ath but not re	sulting in the u	nderlying o	ause give	en in Part I.						cause of death?
The law requires to rate has been signe page 2 should be completed by						. <u></u>				_	24a. Was a autop perfor	sy med?	24b. Were prior to death	o comp ?	y findings available bletion of cause of
Vital siclan: Ti certificate irector, pa		25. Was case referred to medic	al						26. Place	of Death	Check only or			03 2	
of Vita Physiclan: rthis cartific ral director, if		examiner? 1 ☐ Yes 2X No	F	lospital: 1 ☐ In	patient 2	☐ ER/Outpatier	t 3 🗆 DC	Othe	er: 4 □ Nu	rsing Hon	ne <b>≸</b> ∰Resid	ence 6	□Other (S	pecify)	
Vision of Vital Attending Physiclan: redath. scior: After this certifica yy the funeral director; g		27. Manner of Death 1 X Natural 5 ☐ Pend 2 ☐ Accident inves	ling tigation	28a. Date of (Month	Injury , Day Year)	28b. Time of Injury	M 2	8c. Injury Work		2	8d. Describe h				
S BEE 2 T		3 ☐ Suicide 6 ☐ Could	d not be mined	28e. Place of building	of Injury - At I g, etc. (Spec	home, farm, str	eet, factor	, office		2	8f. Location (S City or Tow	treet and n, State)	Number or	Rural F	Route Number,
DIVI To the Hospital or At within 24 hours effar of completely filled in by Medical Certiff		29a Certifier Land Certify (Check only ane)	ing Phys Il Examii	nician: To the to ner: On the base and manny	sis of examin	owladge death ation and/or in	occurred vestigation	et the tim , in my op	e date and pinion, deat	d place, a th occurre	nd due to the o	aus a(s) a late and p	nd n anner lace, and d	as stat ue to th	ed. ne cause(s)
To the within To the comple		29b. Signature and title of certif	ier /	fule	~_		290	D005	number 7475				signed (Ma		ly, Year)
10		30. Name and address of perso Dr. Ari D. Fis	hman	5530	Wisco	nsin Av	e #11		Chevy	Chas	e MD 20	815			
State Registrar		31. Date filed (Month, Day, Yea JUN 0	6 20	06 32.	gistrar's Sign	atur A	mode	,							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** Shakespeare 2006 16:27 Helen Cortney June 4 PΜ /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/ABaltimore Johns Hopkins - Bayview If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. January 25, 1924 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 □ M 2 🛛 F PA 82 218-12-8467 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10b. County 10a. State or than "natural", or Items 23s or 28s-f show the Medical Examiner must be nutified at 1 ☐ Yes 2X No Dundalk Baltimore Maryland Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21222 3116 Sollers Point Road Funerai death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Yes 2 No filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3X Widowed 4 ☐ Divorced Year or Dates: eted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) I Hygiene. Comple Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 11 years 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any lipiny or other traumatic event 2008. Be Roy Perrell Lena Esworthy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3116 Sollers Point Road, Dundalk, Maryland 21222 Linda Bost Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) June 8 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery Dundalk, MD. 2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. M complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each ling. 23a. Part1. Enter the disease of shock, or heart failure. Lis Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a nsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records. funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 10 1□ Yes 2□No 1 Yes 25. Was case referred to medical 26. Place of Death Check only one examiner' Other: 4 Nursing Home Hospital 3D DOA Certification: To 5 Residence 6 Other (Specify) 1 Tyes 1 🗌 Inpatient 2 ER/Outpatient SIL 27. Manner 1 Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospitel or Attendi within 24 hours after death To the Funerel Director: A completely filled in by the fu death. investigation 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai 2 Medical fixaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Dev. Year, 29b. Signature and title of certify 30. Name and address of pe death 31. Date filed (Month, Day, Year) State JUN 0 6 2006 Registra

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State of Mary	land / Department of H	lealth and Menta	I Hygiene 2	00

			1 - State Registrar			Certi	ificate of	Death		F	Reg. No.			
	Physici	4	1. Decedent's Name (First, Middle	, Last)						2. Date of Dea	ith	Vaar	3. Time of Death	
	/Medic		Lillian	Α.		Sve	C			JU	NE Bay	, žõo	6 7:53 AM	
	Examir	er	4a. Facility Name (If not institution, Saint Jose	, give street and number) ph Medical	Cente	r	4b. City, Town, o		of Death	חכ	4c. Co	Bal	timore	
	Funeral Director		5. Social Security Number 215-24-8127	6. Sex 7. Age 1	76		If Under 1 Year Months Days	If Under Hours	Min. D	8. Date of Birth (Month, Day econoer	5,1929	9. Birthi Cou. Mary.	place (State or Foreign htry) Land	
	death with the Maryland ma 23a or 28a-f show (must be notified at	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Balti	more	10c. City, Town		tion dalk						10d. Inside City Limits 1 ☐ Yes 2 X No	
	or 28s	Director	10e. Street and Number				10f. Zip Code			1	l 0g. Citizen	of What Cou	ntry?	
	th wit	aiD	3546 McShane Wa	ıy			212	22			J	JSA		
2-003e	in 72 hours after death with the Marylan "natural", or Itama 23a or 28a-f show tedical Examinar must be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 🌠 Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 💆 N If Yes, Give Year or Dates:		If Y	is Decedent of H 'es, specify Cuba Yes 2X No	lispanic Origan, Mexican Specify:	gin? (Spec n, Puerto R	offy Yes or No- lican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White			
0-017	within 72 ho iene. than "natur ne Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)		+)	(Give kir. life. DO	nt's Usual Occup nd of work done of NOT use retired	ation during most d)	t of working	g		6b. Kind of Business/Industry		
A	illed withir Hygiene. other than		9 years 17. Father's Name (First, Middle, L	( ant)	H	ouse	wife	10.11-11-		/m:		n Home		
yıand	v & 2 ≥ €	To Be	John Zunt					Anto	onia 1	(First, Middle, 1 Matula				
2	0 =		19a. Informant's Name/Relationsh Darlene Gentile		67	39 W	Address (Street a							
Dallimore	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		20a. Method of Disposition  1  Burial 2 □ Cremation  4 □ Donation 5 □ Other (Sp	pecify)		v, cremat	on (Name of tory or other place aith Cemet		June 200	ể 6 <b>,</b> 06 □		ion·CityorTo ale, Ma	own, State aryland	
ם	permit Depart Import any in		21. Signature of Funeral Service L	C. Con	nelle	71	hreitý 10 Solle	ers Po	oint 1	Road, D	undal	k,P.A. k,Mary	land 21222	
			23a. Part1. Enter the disease or a shock, or heart failure. Vist of	complications that caused tonly one cause on each line	the death. Don	t enter t	the mode of dyin	g, such as	cardiac or	respiratory arre	est,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death)	GASTRO	DINTEST	TINA	L - BL	EED.					Onset and Death	
	/Medical Examiner		resulting in death)		FAILUF									
		e.	Securitially list conditions by Due to (or as a consequence of):											
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	НҮРОТЕ	ENSION									
ĵ.	ian an urial-tr		resulting in death) Last	Due to (or as a	consequence o	f):								
00/00	ate be	/Medical	1	d										
O. DOX O	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at the 9 Unknown	Fetal death		topic pregnancy ther (specify)				23d.	Date of delive	ry Day Year	
	that the ed by detac		Part II. Other significant condition	ns contributing to death bu	t not resulting in	the unde	erlying cause give	an in Part I		23e. Did toh	acco use c	contribute to th	e cause of death?	
colus,	requires een sign hould be	sted by					, , , , , , , , , , , , , , , , , , , ,			1 □ Ye			ably 4 □Unknown	
מו חפר	To the Hospital or Atlanding Physician: The law requires that the death within 24 hours after death. To the Euneral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	Completed								24a. Was ar autops perform 1 Yes 2	n 24 y ned? PA No	tb. Were autop prior to con death? 1 \( \sum \text{Yes}	osy findings available inpletion of cause of	
2	sicial s certi lirecto	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 K Inpatien	2 DED/O		3D DOA Othe			Check only on	-			
5	ig Phy ter this neral d	n: To	27. Manner of Death	28a. Date of Injury			28c. Injury Work	4 🗀 Mur		5 Reside d. Describe ho			')	
200	Attendir death. ctor: Af y the fur	Certification:	2 Accident investigation investigation 6 Could not determine the could not be could	ation ot be			M 101	Yes 2□N		f Location (Str	reat and No.	mher or Rura	Route Number,	
2	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral or the funeral		4 🗆 Admicide	building, etc.	(Specify)		,			City or Town	, State)			
	the Hos hin 24 ho the Fun npletely	Medical	one)	3 Physician: To the best of examiner: On the basis of and manner sale	examination and	death oc	tigation, in my op	oinion, deati	d place, and h occurred	at the time, da	ite and plac	ce, and due to	the cause(s)	
1	S S S		29b. Signature and title of certifier	Tabas	il	1	29c. License	number 5356			une i	gned (Month, L	Day, Year)	
(	l		30. Name and address of person w				ER DRIV	VE. T	rowso	ON. MO	RYL Q	ND 218	2014	
	Sta Registra		31. Date filed (Month, Day, Year)	32. Redistrar		ho	and I					year tomat h	mar emi' I	

		1	For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of H		1ental Hygie	_/HH:	17776
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physicia		Dolly	Mav	Stanie	C			, 2006	11:40 A M
-	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death		4c. County of De	
			611 Long Bar Harb			Abingo		15:0	Harfor	
	Funeral		5. Social Security Number 6. Security Number 1 6. Security Number 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7.Age M 2 🔯 F	(In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye June 8,	ear) (	irthplace (State or Foreign Country) ryland
	Director	-	Usual Residence of Decedent		03			June o,	1920 PM	Lylana
	yland yland		10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	a-f st	ctor	Maryland Harfor	d	Abing	don				1 ☐ Yes 2 XNo
	ith th	Dire	10e. Street and Number	on Dond		10f. Zip Code 2100	19	10g.	. Citizen of What ( USA	Country?
	s 23s	rai	611 Long Bar Harb	12. Was Decedent E	verin U.S. 13	Was Decedent of Hi		ecify Yes or No-		nerican Indian,
9	within 72 hours after death with the Maryland nne. "Medical Examinat must be multified at "Medical Examinat must be multified at	y Funerai Director	11. Marital Status  1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	0	If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	Specify:	Rican, etc.)	Black, Wi	
Ö	hour:	ed by	3X Widowed 4 □ Divorced  15. Decedent's Edu	Year or Dates:	16a. Dece	dent's Usual Occupa	ation		b. Kind of Busines	:s/Industry
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212	_ = _ =	E O	8		Home	maker			Own Home	:
pu	be filed stal Hygi od other evant, I	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma. Tosephine		
<u></u> ✓	Men Men arka atic	2	John Peter Hayes  19a. Informant's Name/Relationship (T)	ine Print)	19b Maili	ng Address (Street a		ral Route Number, C		, Zip Code)
Maryland	nd 2 s lith ar 27 is r trau		Sharleen D. Callar	an/Daught		Long Bar	r Harbor	Road, Abi	ngdon, M	ID 21009
Baltimore,	1 a Heg Hem tem		20a. Method of Disposition  1 □ Surial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	Removal from State	20b. Place of Dispo cemetery, cre Aberdeen	matory or other plac	(8)	ne Ab	erdeen Fround, ME	roving
Baltir	permit. Pages Department of Important: If if any injury or c		21. Sure ture of Funeral Service Urbens	man Do	7	2. Name and Address MCCOMAS Fi	uneral Ho			
		П	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused	the death. Wo not en	ter the mode of dyin	ig, such as cardiac	or respiratory arrest	t,	Interval Between
B	Pnysician		Immediate Cause (Final disease or condition	Meta	storbe	Recta	l com	cer		Unset and Death Hoonths
	/Medical Examiner		resulting in death)	a.	a consequence of):	•				
В	Examine	<u></u>	Sequentially list conditions, if any leading to immediate	b. Due to (or as a	a consequence of):					
Ţ	nted I Insit	mine	Cause (Disease or injury							
v O	execu an and rial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a	a consequence of):					
3760	cate be executed physician and s the burial-transit	icai		d						
9	death certifica a attending ph d for use as ti	/Med	IF FEMALE:	23c. If ves. outcome	of pregnancy			W-	23d. Date of	delivery
. Box	death of atten	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify) _	/		Month	Day Year
P.0	res that the designed by the a	Phys	9 Unknown  Part II. Other significant conditions of		it not resulting in the	underlying cause giv	ven in Part I.	23e. Did toba	cco use contribute	to the cause of death?
Records,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	d by	Parti. Other Significant contacts of					1 🗆 Yes	21 <b>X</b> No 3	Probably 4 Unknown
900	aw require as been si 2 should b	Completed						24a. Was an autopsy	prior	autopsy findings available to completion of cause of
- B	The ate his page	Com						performe	ed? death YNo 1 □ Y	es 2000 No
Vital	cian: ertific actor,	Be	25. Was case referred to medical examiner?	Hospital:		Ctt	200	ath Check onl one		
of	Physician: this certific ral director,	2	1 Yes 2 No	1 U inpatie		ent 3 DOA	4   Nursing n	lome 5 vesiden 28d. Describe how		pecify)
on	Jing After fune	tion	1 Natural 5 Pending 2 Accident Investigation	28a. Date of Inju (Month, Day	Y Year) Injury	Wo	rk?  Yes 2□No			
Division	Attending or death. actor: After by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injusting, et	ury - At home, farm, s	treet, factory, office		28f. Location (Stre City or Town,	eet and Number or State)	Rural Route Number,
ā	spitat or At	Cert				- Marchal			( )	
	Fur Fur	ledical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best iner: On the basis of and manner sta	of my knowledge, dea f examination and/or i ated.	ath occurred at the ti investigation, in my o	me, date and place opinion, death occu	e, and due to the cau arred at the time, date	e and place, and	due to the cause(s)
	othe comple	Me	29b. Signature and title of certifier	04100	IAA NID	29c. Licens	se number		d. Date signed (M	onth, Day, Year)
	(4)		30. Mame and address of person who	completed cause of o	leath (Item 23a) (Type	e, Print)	6t. m	2000:	. 112-	210111
			31. Date filed (Month, Day, Year)	32. Saistr	ar's Signature	road,	, 71 201	Bull		7
	Regist	tate trar	30. Name and address of person who so the second of the se	006	in the fig	224/4				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 10b per fh 8856 6-6-06 vt
State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** SCHUSTER 3:15 P M 2006 Vune /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital of Baltimore Cita Sinai Baltimore N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country POLAND 6. Sex 8. Date of Birth 5. Social Security Number **Funeral** 1 M 2 □ F Months Days Hours 09/05/1920 85 213-34-7155 Director Usual Residence of Decedent 10a State 10b. County Baltimore 10c, City, Town of Location 10d. Inside City Limits 28a-f show t of Health and Mental Hygiene. If item 27 is marked other then "natural", or Items 23e or 28a-1 shos or other traumatic event, Ite Medical Examinat must be notified at 1 ☐ Yes 2 No Director BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3409 WOODVALLEY DRIVE 21208 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: WHITE Specify. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNER RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **SCHUSTER FEFFER** BAT SHEVA BERYL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2:1
Department of Health at Important: If item 27 is any niury or other trau 3409 WOODVALLEY DRIVE - BALTIMORE, MD 21208 DEBORAH SCHUSTER / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State BETH TFILOH CEMETERY 6/5/2006 WOODLAWN, MD 4 □ Donation 5 □ Other (Specify) re Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) nset and Death sepsis syndrome week Physician /Medical Due to (or as a consequence of): Examiner WEEL Dheumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last but to (or as a consequence of): Examiner physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 cate has been sign page 2 should be terstitial lung disease 3 Probably 4 □Unknown 1 Yes 2 No Be Completed artery disease 24b. Were autopsy lindings available prior to completion of cause of death? autopsy performed? my ocardial infarction non ST elevation certificate 1 ☐ Yes 2 € No 1 ☐ Yes 2**1**No funeral director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dinpatient 2 ER/Outpatient 3 DOA 1 Yes 2 0 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 ANatural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) RES-000 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jinai Hospital of Baltimore Clander MO 32 Registrar's Signature 31. Date filed (Month 0 6 State 2006

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Registrar

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	Physici	ion	1. Decedent's Name (First, Middle	, Last)				2. Date of Death Month	Day	3. Time of	Death
	/Medi		Charles Tressl					May 25,	2006	0130	a <sup>M</sup>
7	Examir	ner	4a. Facility Name (If not institution	-			Location of Death		4c. County		
			Homewood-Frede  5. Social Security Number		ng Home Age (In yrs. last birthday	Frederic	If Under 24 Hrs.	R Date of Righ	Freder		- Foreign
L	Funeral Director		183-18-6607	1⊠M 2□F	83 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Jun 29,	<sup>Year)</sup> 1922	9. Birthplace (State or Country) PA	<i>r-oreig</i> n
	land		Usual Residence of Decedent  10a. State 10b. County	77	10c. City, Town or L	ocation				10d. Inside Cit	v Limits
	Many -1 sh	ţŏ	MD Frede	rick	Frederic					1 🗀 Yes	2 <b>X</b> No
	r 28a	irec	10e. Street and Number	TICK	Trederic	10f. Zip Code		10	g. Citizen of W	hat Country?	
	th wit	Funeral Director	7407 Willow Roa	d		21702			USA		
	r dea	Iner	11. Marital Status	12. Was Decede Armed Force	int Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No-		- American Indian, K, White, etc.	
36	s afte	by Fu	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	If Van Chin	□ No s: <b>'</b> 42 <b>–</b> 45	1 ☐ Yes 2X No	Specify:	,	Specify:		
	72 hours after death with the Maryland natural; or items 23a or 28a-f show dical Examinar must be incitified at	ed b	15. Decedent			dent's Usual Occupa	ation		6b. Kind of Bus	white	
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21Z	filed within Hygiene. other then " ent, the Med	E O	Elementary/Secondary (0-12) unk	College (1-4d		ege Profes	ssor		Educat	ion	
ם	al Hyg I othe vent,	Be C	17. Father's Name (First, Middle, L	.ast)				e (First, Middle, M			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar f Health and Mental Hyglene. If Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avent. The Medical Examinar invality is cultified at	70	Harvey Edward T	ressler				na Tress			
lar	2 sho and is mu		19a. Informant's Name/Relationsh			ng Address (Street a				State, Zip Code)	
	1 and 2 Health em 27 ther tr		Homewood-Freder	ick Nur. Ho	ome 7407  20b. Place of Disp	Willow Rd					
Baltimore,	Page nent o ant; ff ury or		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☒ Donation 5 ☐ Other (Sp.			matory or other place	θ)	Date 2	Oc. Location - C	City or Town, State	
Ball	permit. Pag Depertment Important; f any injury o		21. Signatura Funeral Service L Ronald		rector S	2. Name and Addres Late Anato altimore,	omy Board		Baltimo	ore Street	
Н			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that cause on each	sed the death. Do not en				st,	Approximate Interval Betw	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		BRAL VA:	CHLA	2 Ace	IDENT	_	Onset and De	eath
	Examiner		Sequentially list conditions	b							
	ם ב	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury		as a consequence of):						
	ecute and -trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c.							
8/60,	s be executed sician and burial-transit		, , , , , , , , , , , , , , , , , , ,	Due to (or	as a consequence of):						
Ω	physic physic s the b	edical		d							-
рох б	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor					23d Date	of delivery	
ň	death of atten	Physician/M	in the past 12 months?	4☐Pregnant	at time of death 5	Ectopic pregnancy Other (specify)			Mont	,	ear
Ö.	that the de led by the detached	hys	9 Unknown	9□Unknown	1						
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D	law requires as been sign 2 should be							1 🗆 Yes	2 <b>₽</b> No 3	B ☐ Probably 4 ☐Un	ıknown
Vital Records,	e law r has be je 2 sh	ompleted						24a. Was an autopsy	pri	ere autopsy findings av	variable use of
E .	ate pag	S						performe		ath? ⊒Yes 2.⊒No	
Ĭ	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Otho		h (Check only one			
Ö		. To	1 Yes 2 No  27. Manner of Death	1 □ Inpa		at 3 DOA	" 4 Nursing Ho	me 5 Residen 28d. Describe how			
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		erti	4  Homicide determin	building,	etc. (Specify)			City or Town,	State)		
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physicien: To the be xaminer: On the basis and manner	st of my knowledge, deat s of examination and/or in stated.	n occurred at the tim vestigation, in my op	e, date and place, pinion, death occurr	and due to the cau red at the time, dat	se(s) and manr e and place, an	ner as stated. Indicate to the cause(s)	
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier	/ -		29c. License	number			(Month, Day, Year)	
	->-0		Andrew	- Donel	son mo	3:	21936		5/24/	06	
			30. Name and address of person w	no completed cause o	f death (Item 23a) (Type,						
			ANDREW DON	BLOON	65C 7HAY	MAS VOH.	Noon D	R FR	EDER	rck 217	62
	Sta		31. Date filed (Month, Day, Year)	32. Regi	strar's Signature	Page 15 D		-			
	Registr	ar	JUN 0 6	2000	Euro Dr. So	ASTRAL PROPERTY.					

		State of Maryland / Department of Health and Mental Hygiene				
		1 - State Registrar Certificate of Death Reg. No. 2 0 0	Reg. No. 2 0 0 6 1 7 7 7 9			
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		Maryland General Hospital Baltimore City NIA				
- Funeral Director		10 70 110/2 1 1 M 2 KF 1/2 Vrg Months Days Hours Min. (Month, Day, Fear)	nplace (State or Foreign untry)			
pug &		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				
with the Maryland a or 28a-f show	jo		10d. Inside City Limits 1   Yes 2   No			
r 28a	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Cou	untry?			
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other tra		VERNICE GOODWIN GAUGHTER 5005 SUNSET ROAD, BALTIMORE, M.				
J O %2= 5		20a. Method of Disposition  20b. Place of Disposition (Name of cometery, crematory or other place)  20c. Location - City or T				
Baltimo Permit. Page Deperment of Important: If eny injury or		4 Dongton 5 Other (Specify)  KING MEMORIAL PARK 06-08-2006 CALTIMORE  21. Signal of Funeral Service Licensee	, INHAILHAU			
Balt Deermit. Depertrimental importations on a process.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  305EPH H. BROWN JR. FUNERAL HOM  2140 N. FULTON AVE, BALTIMORE, MIL	ME 201217			
6		shock or heart failure. List only one cause on each line	Approximate Interval Between			
Physician		Immediate Cause (Final disease or condition resulting in death)  a. Carcinoma of the Breast	Onset and Death			
/Medical Examiner		to (or as a consequence of):				
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18760, cate be executed physician and ithe burial-transit		resulting in death) Last Due to (or as a consequence of):				
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Box 6 leath certific attending p	M/M	IF FEMALE:     23b. Was decedent pregnant     23c. If yes, outcome of pregnancy     23d. Date of deliv       23b. Was decedent pregnant     1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy     23d. Date of deliv	ery			
Division of Vital Records, P.O. Box 6  To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death.  To the Funeral Director: After this certilicate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	In the past 12 months?  1  \[ \text{Live birth} \ 2 \] \] \[ \text{Fetal death} \]  1 \[ \text{Ves} \ 2 \] \[ \text{Vho} \]  9 \[ \text{Unknown} \]  1 \[ \text{Live birth} \ 2 \] \[ \text{Fetal death} \]  5 \[ \text{Other} \ (specify) \]  9 \[ \text{Unknown} \]  Month	Day Year			
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Division of Vital Records, I or Attending Physician: The law requires ta after death. Director: After this certificate has been signed in by the funeral director, page 2 should be	ed by		bably 4 Unknown			
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or Att frer de precte in by t	Certification:	3 ☐ Suicide 4 ☐ Homicide  3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  5 ☐ Could not be determined  5 ☐ Could not be determined  6 ☐ Could not be determined  6 ☐ Could not be determined  6 ☐ Could not be determined  6 ☐ Could not be determined  7 ☐ Suicide  6 ☐ Could not be determined  8 ☐ Could not be determined  8 ☐ Could not be determined  9 ☐ City or Town, State)	al Route Number,			
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To ti withii To ti comp	Ž	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month,	Dey, Year)			
n		1948 XXX D 58779 9/3	30/06			
2		30. Name and address of person who completed cause of death (Item 23a) (Type Print) K05aun Raker; M. O. 40 Maryland General Hospit	tall			
Sta	te	31. Date filed (Month, Pay, Year) 32. Registrar's Signature				
Registr	ar	JUN 0 6 2006 Selection 25 September 25				

			1 _ State	f Maryland / Dep	partment of I		-	0.07	
1 '			Registrar  1. Decedent's Name (First, Middle, Last)		Tillicale of	Dealli	2. Date of De	Reg. No.	3. Time of Death
	Physici		John Conrad Taylor				Month	Day	Year
	/Medic Examir		4a. Facility Name (If not institution, give street and nu	mber)	4b. City, Town,	or Location of De	June	4c. County	
	LXamii		2104 Flintshire Road, A	Apt. 102	Roseda	le		Bal	timore
	Funeral	-	Social Security Number     6. Sex	7. Age (In yrs. last birthda)	/) If Under 1 Year Months Days	If Under 24 H		h v Year)	Birthplace (State or Foreign Country)
	Director		220-32-3412 <sup>1</sup> ⊠ <sup>M 2□</sup> F	68 Yrs.	Monins Days	Hours M	Feb. 13		Maryland
	pu *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	conting				10d. Inside City Limits
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	the M	Director	Maryland Baltimore  10e. Street and Number	Roseda	10f. Zip Code			10= Ohi11	
	i within 72 hours after death with the Maryland liene. r than "natural", or Itams 23a or 28a-f show the Medical Exeminet must be notified at		2104 Flintshire Road		212	237		10g. Citizen of V USA	•
	ns 23	Funeral		edent Ever in U.S. 13	. Was Decedent of I		(Specify Yes or No	14. Race	e - American Indian.
0	ritar	듄	Armed Fo	orces? 2 No	If Yes, specify Cub	an, Mexican, Pu	erto Rican, etc.)		ck, White, etc.
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allo	Ibe fi	Be	17. Father's Name (First, Middle, Last)  John Edward Taylor				<sub>lame (First, Middle,</sub> Marie Kne		10)
Ĕ	should nd Mer marks umatic	2	19a. Informant's Name/Relationship (Type, Print)	10h Mai	ling Address (Street	l .			Chata Zin Codel
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<u> </u>	Pages nent of int: if it iry or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State		i i	7.06	Пет т	M11
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VISION	Attending r death.	cati	2 Accident investigation 3 Suicide 6 Could not be		M 1	Yes 2 □ No			
$\geq$	or Ati	ertification:	determined 288. Place	of Injury - At home, farm, s ing, etc. <i>(Specify)</i>	treet, factory, office		28f. Location (S City or Tow	Street and Numbern, State)	er or Rural Route Number,
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	To the Hospital or Attanovithin 24 hours effer death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one)  1	best of my knowledge, dea asis of examination and/or i ner stated.	ith occurred at the ti nvestigation, in my o	me, date and pla opinion, death oc	ce, and due to the o curred at the time, o	cause(s) and mai date and place, a	nner as stated. and due to the cause(s)
	To the Hos within 24 h To the Fun completely	Mec	29b. Signature and title of certifier		29c. Licens	se number		29d. Date signed	(Month, Day, Year)
	~ s ~ ŏ		Millon. 10	110	Dno	27/09	3	6/3	2/2006
	4		30. Name and address of person who completed caus	se of death (Item 23a) (Type	p. Print)			7/2	1
	0		Michoel A /dy /R	nD 6530W	ethers for	erue.	Boltom	ne mel	2/266
JA S	Sta	ite		gistrar's Signature	Rock .	-			2/2006
	Registr	ar	JUN 0 6 2006	Religion D. A.					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Annie Wilson 10:30 A<sub>M</sub> May 30 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bon Secours Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 □ M 2 🕅 F Director 213-32-9453 Yrs. 92 09-13-1913 South Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If Item 27 Is marked other than "natural", or Items 23s or 28a-f show ury or other traumatic event, I'm Modical Examinations to a notifical at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 229 N. Mount Street 21223 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ZNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify 3 X Widowed 4 □ Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Durant 2 Eugenia Durant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joann W. Strickland/ Granddaughter 1629 Spence Street Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Naurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 4 Donation 5 Other (Specify) Mt. Zion Cemetery 106-05-06 Lansdowne, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor Street Balto, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a cor Examiner Sequentially list conditions, any leading to minimize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-tran Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 4☐Pregnant at time of death Day Year 5 Other (specify) Yes 20/10 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completic of cause of death?

1 ☐ Yes 2 → 1 24a. Was an this certificate has autopsy performed? Division of Vital 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No P 1 Inpatient 2 ER/Outpatient DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Injury investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6/2/06 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of p 940 W. BART ST. BANT MO 21223 ANTHONH MD JOSEPH 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JUN 0 6 2006 Registrar

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the M	Director	MD 10e. Street and Nun	NA NA						10f. Zip		ore.		10	Or Citizen	of What Cou		
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should be filed within 72 hours after death with the Maryland nd Mental Hygiene. wmarked other than "natural", or Items 23a or 28e-f ehow umatic event. I're Medical Examinar must be notified at	d by	3 Widowed	4X Divorced	,	f Yes, Give rear or Dat	tes:			T T T T T T	24L NO	Specify:			Spe	cify: B1a	ack	
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id be ental ked c	To Be	James E.	West								Met	tie B.	Hughes	5			
shou ind M mar		19a. Informant's Na	ame/Relations	hip (Type, i	Print)		19	b. Mailir	ng Address	(Street	and Number or				vn, State, Zi	p Code)	
and 2 ealth a n 27 ie		Marcus Hill	/ Sốn				8	12 Na	at Ct.	Apt :	2 Baltimo	re, MD	21212				
of He of He f Item		20a. Method of Disp		3 □Bamo	wal from Si	- 1	20b. Place cemete	of Dispo ery, cren	sition (Nari natory or o	ne of ther plac	e)	Date	2	Oc. Locatio	n - City or T	own, State	
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permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: if Item 27 ie marked other than "natural; any injury or other traumatic event, Ira Medical Exa ODEs.		21. Signature of Fu	neral Service	Licensee							ss of Facility						
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w require been sig should b	ed 1							_				-	1 🗌 Yes	2 □ No	3 ☐ Proi	bably 4 Donknown	
The law rate has be page 2 sh	Completed											-	a. Was an autopsy perform Yes 2	ed?	b. Were auto prior to co death? 1 \( \sum \section \text{Yes}	opsy findings available omptetion of cause of	1
certificate	Bec	25. Was case refere	red to medica								26. Place of D						
hysic his ce il dire	2	1 ☐ Yes 2 🗽		Hosp	tal: 1 🖫 📊	patient	2 🗆 ER/O	utpatien			4 🗆 Nursing	Home 5	Resider	nce 6 🗆 C	Other (Speci	fy)	
Attending Physician: or death. •ctor: After this certifica by the funeral director.	Certification:	27. Manner of Death  1 Natural  2 Accident	5 🗌 Pendir investi	gation	Ba. Date of (Month)	Injury Day Y	ear) 28b.	Time of Injury	M 2	8c. Injun Worl	yat k? Yes 2 □ No	28d. De	scribe hov	v injury occ	curred		
rs after d ai Direct ed in by	Certific	3 ☐ Suicide 4 ☐ Homicide	6 □ Could determ	ined 2	Be. Place of building	of Injury g, etc. (	- At home, f Specify)	farm, str	eet, factory	, office		28f. Loca City	ation (Stre or Town,	et and Nu State)	mber or Run	al Route Number,	
To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai	29a. Certifier (Check only one)	1 Certifyir 2 Medical	Examiner:	n: To the b On the bas and manne	sis of ex	amination a	ge, death ind/or inv	n occurred vestigation	at the tin , in my o	ne, date and pla pinion, death oc	ice, and due curred at the	to the cau time, dat	use(s) and te and plac	manner as s e, and due t	stated. o the cause(s)	
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1		30. Name and addre	KHER	-2€	=	56			Print)	2 A	VEN	Bou	LEV	ARC	) Bi	ALTIMOR MD 21239	26
Sta Registr	-	31. Date filed (Mont	th, Day, Year)			distrar's	Signature	1	Speek	2							

			1 - State Registrar	State of M	larylar		artmer <i>rtificat</i>			d Mental Hy	giene Reg. No.	006	17783
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	Director		Usual Residence of Decedent	ŬM 2□F	56	Yrs.	Months	Days	Hours N	1in. (Month, Da 08–25–1		South	Carolina
	the Marylan 28a-f show	Director	10a. State UNK 10b. County WN  10e. Street and Number WNK	/K	10c. Cit	y, Town or Lo		Code at	NV		10g. Citizen o		0d. Inside City Limits 1 ☐ Yes 2 ☐ No
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9036	should be filed within 72 hours after death with the Maryland of Menla Hygene. marked other than "naturel", or liems 23a or 28a-f show marked other than "nature "nature".	by Funeral	11. Marital Status  1X Never Married 2  Married 3  Widowed 4  Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 X If Yes, Give Year or Dates:	? ] No		Was Dece If Yes, spe 1  Yes	cify Cubai	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No Jerto Rican, etc.)		ace - Americ ack, White, ify: Black	etc.
21215-(	d within 72 h piene. r than "natu	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		5+)	16a. Dece (Give life.	kind of wo DO NOT u	rk done d	uring most of	working	16b. Kind of	Business/In	•
yland ;	d ta b	To Be C	17. Father's Name (First, Middle, Last)  Tommy Wilkes						18. Mother's f	Name (First, Middle, Nanny Sa	Maiden Suma anders	ame)	
Baltimore, Maryland 21215-0036	1 and 2 a Health ar In 27 is ther trau		19a. Informant's Name/Relationship (7) Sallie E. Wilkes 20a. Method of Disposition				ilrim	Road	Chester	Rural Route Number SC 29706	er, City or Town 20c. Location		
Itimo	nit. Pages artment of I ortant: If its injury or o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service License		9	Prospec	t Cerne	tery	1	10-06	Chester	, SC	
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•	3		30. Name and address of person who co	ompleted cause of	death (Item	23a) (Type,	Print)	15-6	100	love, NI	SUME	4 20	000
	Sta Registr		31. Date filed (Month, Day, Year)  11 N 0 6 2006	2. Regist	rar's Signa	ture form	e >-	+ <u>/_</u>	Altin	DRC, IVI	ARY MAIN	1 2	1287

			For State	State of Maryland		rtment of He			iene	06	17784
			Registrar  1. Decedent's Name (First, Middle, Last)			.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		2. Date of Deat	h	Year	3. Time of Death
	Physicia /Medic		Alice R. White	2				1 1		2006	0417 AM
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			Union Memoria  5. Social Security Number 6. Securit	7 Age /le um last	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1		place (State or Foreign
	Funeral Director		218-09-3351	M 201 F 92	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	1 <sup>year)</sup> 3	Cou	aryland
	D.		Usual Residence of Decedent	10c. City, T		-atina					10d. Inside City Limits
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	28a-f	Director	10e. Street and Number	Ба	TLI	10f. Zip Code		11	0g. Citizen o	f What Cou	71
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	ems ?	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of His Yes, specify Cuban	panic Origin? (Sp., Mexican, Puerto	ecity Yes or No- Rican, etc.)		ace - Ameri lack, White,	
9	e filed within 72 hours after death with the Maryland al Hygiene. I other than "neturel", or flems 23a or 28a-f ehow vent, the Madical Exeminal must be notillised at	by Fu	1 Never Married 2 Married 3 XWidowed 4 Divorced	1 ☐ Yes 2 ₩ No If Yes, Give A Year or Dates:		7.7	Specify:		Spec		frican-
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ore	Pages 1 nent of H int: If Iter iry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	lemoval from State	of Disposatery, crem	sition <i>(Name of</i> natory or other place .Vary	)	Date :	20c. Location		
Baltimore,	permit. Pages Depertment of Important: If it any injury or once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens		-		,				Balto. Co
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	eath certificat attending phy I for use es the	M/us	23b. was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de		Ectopic pregnancy				Date of deliv	•
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Division of Vital Records,	or Attendate deatl	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of fnjury - At home building, etc. (Specify)	, farm, str	eet, factory, office		28f. Location (St. City or Town		nber or Rur	al Route Number,
	To the Hospital or At within 24 hours after d To the Funeral Direct		29a. Certifier 1 Certifying Phy	sician: To the best of my knowle	dge, death	n occurred at the time	e, date and place	and due to the ca	ause(s) and r	manner as s	stated.
	n 24 h n 24 h he Fu	Medicai	(Check only 2 Medical Exami	ner: On the basis of examination and manner stated.	and/or inv	estigation, in my op	inion, death occu	rred at the time, da	ate and place	e, and due t	o the cause(s)
	within To t	Σ	29b. Signature and title of certifier	MI		29c, License			9d. Date sigr		
	1		MUU U	emploted cause of death (the of	a) (Tues	A120	4)014	ا ط	June	05	2006
	<sup>2</sup>		30. Name and address of person who c	By M.D. (L)	h. The	AT2	Hospital	MD			
	Sta		31. Date fifed (Month, Day, Year)	32. Registrar's Signature			1	•			
611	Regist	- 1	JUN 0 6 20	106 James L	· P	parte					
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ORIGINAL

			for State Registrar	State of Maryla		nent of He			iene 2006	17785
	Physici /Medic		1. Decedent's Name (First, Middle, Last, Ehzass		eston	,		2. Date of Death	Day Year	3. Time of Death
	Examir Funeral Director		4a. Facility Name (If not institution, give  NORTHWEST H  5. Social Security Number 6. Sec  219-10-0236	street and number)	-NE	PAN Inder 1 Year	ocation of Death  AHIS Zo  If Under 24 Hrs.  Hours Min.	ما	4c. County of Deat  BA LT  Year)  9. Birth Co	n PM  r  nplace (State or Foreign untry)  V JERSEY
0036	is 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If the Examination of the Hygiene is the Hygiene in the Hygiene is the Hygiene in the Hygiene in the Hygiene in the Hygiene is the Hygiene in the Hygiene in the Hygiene is the Hygiene in the Hygiene is the Hygiene in the Hygiene is the Hygiene in the Hygiene is the Hygiene in the Hygiene is the Hygiene in the Hygiene is the Hygiene in the Hygiene is the Hygiene in the Hygiene is the Hygiene in the Hygiene is the Hygiene is the Hygiene is the Hygiene is the Hygiene in the Hygiene is t	d by Funeral Director	1   Never Married 2   Married 3   Widowed 4   Divorced	RD E.  TREE WAY,  12. Was Decedent Ever in U. Armed Forces?  1 — Yes 2 Mo. If Yes, Give Year or Dates:	UNITC O	f. Zip Code	panic Origin? (Sp , Mexican, Puerto Specify:	ecty Yes or No-	Og. Citizen of What Co	rican Indian,
S	be filed within 72 filed Within 72 filed Hygiene. I other than "nate vent, the Madica	Be Completed	15. Decedent's Edu (Specify only highest gradi Elementary/Secondary (0-12) 12. TH CRADE 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	HOME	of work done du OT use retired)	ring most of work  18. Mother's Nam	ing		OME
more, Mary	permit. Pages 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e once.	To	19a. Informant's Name/Relationship (Ty HILDA JONES  20a. Method of Disposition  1 Burial 2 GCremation 3 Dt 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licens	DAUGHTER)  20b. Removal from State	19b. Mailing Add 1728 CR Place of Disposition cometery, crematory	Institution (Name of or other place	TREE WAR	t, Unit C Date 2 6-2006 B	0c. Location - City or	ip Code) >,MD 21040 Fown, State , MARYLAND
	and certificate be executed attending physicien and for use es the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection).	quence of):	mode of dying,	such as cardiac	or respiratory arre	st.	Approximate Interval Between Onset and Death
. Box 6	0 0	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown	l3c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet: 4 □ Pregnant at time of 6 9 □ Unknown	aldeath 3□Ectop	nic pregnancy r (specify)			23d. Date of deli	very Day Year
	ine law requires ete has been sign page 2 should be	e Completed by	FAILURE - DIAGE VASCULAR DISEASE 25. Was case referred to predical	HADICALYEPA SET-S MELL	THY; CON	THE PARE	PLAL ES.	1 ☐ Yes 24a. Was an autopsy perform	24 Were aut prior to c death?  No 1 \[ \text{Yes} \]	the cause of death?  bably 4 Amknown  opsy findings available ompletion of cause of
Division of V	aing Pnys h. After this funeral dii	Certification; To B	27. Manner of Death  1 Vhatural 5 Pending investigation  2 Accident investigation  3 Suicide 6 Could not be	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	DOA Other  28c. Injury a Work? 1 Ye	4 Nursing Ho	me 5 ☐ Resider 28d. Describe how	nce 6 Other (Spec	
=	Hospital or 4 hours efte Funeral Dir ely filled in I	ledicai Certii	(Check only 2 Medical Examil	building, etc. (Speci sician: To the best of my kno ner: On the basis of examina	fy)  owledge, death occu	rred at the time	date and place	City or Town,	State)	stated
)	within 2-	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number	29	d. Date signed (Month	, Dey, Year)
	3			ENANAN 1	mp	Nio. RAA	LICHWET DAILOTE	Tow go	PROTAL G	21133
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 6 20	32. Registrar's Signa	M Angel	0		,		1

State of Maryland / Department of Health and Mental Hygiene? For State Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 8:20 P Michael Milton Wilfong June 2006 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 1921 Wareham Road Dundalk If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 25, 1949 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 10 M 2□F Months Days Hours Yrs. July Maruland 213-52-4512 56 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director Baltimore Dundalk Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U. S. A. 21222 1921 Wareham Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iten any injury or other traumatic event, the Medical Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 X Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Howard Wilfong Icie Welch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles H. Wilfong (Brother) 5216 Fawn Grove. Pylesville. Maryland 21132 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory 6/8/2006 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. 3331 Brehms Lane, Bultimore, Maryland 21213 Durin (1) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a cons-up-nce of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transi signed by the attending physicien and dbe detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed2 1 Type 2 No 20 or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Certification: To Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. neral Director: / / filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
301 ST. Paul Place Bo. 40. Mo. 2 21202 Paul Day, Year) 0 6 2006 32. Registrar's Signature State

Registrar

06-03685 Harold Wilson

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Reg No. 2008									1//8			
Physicia		Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year 1210 hrs					
Medical Exami	ner	Harold Thomas		lay 30, 2006										
		4a Facility Name (if not institution	41	o. City, Town, or Lo	ocation of Dea	ath	4c County of Death							
	п	Saint Agnes HealthCa	are			Baltimore			N/A					
Funeral		5 Social Security Number	6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year	If Under 24H		Birth (MM/DD/YYY	<ul><li>9. Birthpla</li><li>Foreign</li></ul>	ce (State or			
Director		159-28-3643	74	Yrs.	Months Days	Hours M	Mar.	22, 1932	Country	) MD				
	H	159-28-3643   1 X M 2 F   74 Yrs.   Mar. 22, 1932   Country. Usual Residence of Decedent												
au è.	ı	10a. State 10b. County 10c. City, Town or Location 10d Inside City Lim												
p * .		. MD Baltimore Halethorpe								Yes 2 X No				
daryland 28a-f show any 1 at once.	용	10e. Street and Number		10f. Zip Code					10g Citizen of W	hat Country?				
th the Maryland 23a or 28a-f sho notified at ouce.	Director	1809 Palo Cir		21	227		United States							
ith th		11. Marital Status 12. Was Decedent Ever in U.S.			13 \//as			Specify Yes or	pecify Yes or No- 14 Race - American Indian, I					
eth w		1 Never Married 2 XM	Armed I	Forces?		s, specify Cuban, I								
er death		3 Widowed 4 Div	1 X Yes	2 No	1	Yes 2 X No	specify:		Specify:	Wh:	ite			
hours afte 'natural'', Examiner	ā.		or Dates:	or Dates:			n (Give kind o	of work done		Kind of Business/Industry				
2 hou	ted	Elementary/Secondary (0-12)		(1-4 or 5+)	_	st of working life. D		etired)						
5-0036 led within 72 Hygiene other than '	Completed	12	1		Di	stributi	on		Grocery					
d with	팃	17. Father's Name (First, Middle, Last)  18. Mother's N						Name (First, Middle, Maiden Surname)						
21215-0036 uld be filed within 7 Mental Hygiene marked other than	Be													
212 uld b Meni mari	0	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
MD 21215-0036 at 2 should be filed within 72 hours after death with the Maryland sith and Mental Hygiene in 27 is marked other than "natural", or items 23a or 28a-f she annatic event, the Medical Examiner must be notified at once		Betty L. Wilson - Wife 1809 Palo Circle, Halethorpe, MD 21227												
- B = E = -	ı	2Ca Method of Disposition		20b. Pl	ace of Disposit	ion (Name of ceme		Date	20c. Location		n, State			
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 X Burial 2 Crematio	n 3 Removal	II OIII Glate	ematory or oth don Par		ry 6	-3-2006	Raltin	nore l	vm.			
timen trant	- 1	4 Donation 5 \ Other Specify												
Balti permit Departn Import	- 1	21. Signifure of Funeral Struice Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc.												
	-1	23a Part I Enter the disease of	complications that	caused the death. I	1328 Sulphur Spring Rd., Arbutus, MD 21227 ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Inter									
Physician /Medical		Failtre List only one cause on each line.  Immediate Cause (Final disease a Hyperthermia semplicating-Hypertensive Atherosclerotic Cardiovascular Disease  ### Part I. Enter the disease, or complications and the death of the final disease and the death of the final disease and the death of the final disease and the death of the final disease and the death of the final disease and the death of the final disease and the death of the final disease and the death of the final disease and the death of the final disease and the death of the final disease and the death of the death of the final disease and the death of the final disease and the death of the final disease and the death of the final disease and the death of the final disease and the death of the death of the final disease and the death of the d												
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	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of)	:						,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
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ox 68 sath certil attending	ä	past 12 months?	□ Page						No.	Duy	7 50.			
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Diabetes Mellitus  23e. Did tobac  1 Yes 2							d tobacco use cont	acco use contribute to the cause of death?						
							1'	Yes 2 No 3 Probably 4 Unknown						
Sport of spo								24b. Were autopsy findings available						
SOF law ra has b	Diabetes Mellitus  1 Yes 2 No.  1 Yes 2 No.  24a. Was an autopsy performed?  1 Yes 2 No.  24a. Was an autopsy performed?  1 Yes 2 No.								prior to completion of cause of death?					
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tal Recian: The certificate		25. Was case referred to medical Zo Place of Death (Check only one)												
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27. Manner of Death 28a Date of Injury 28b Time of Injury 28c Injury at Work? 25c 1 X Natural 5 Pending 1 X Natural 5 Pending 1 Yes 2 No.								Exposure	to high enviro		nperature			
ior ttend death rtor: / the	aţic	- I CI	estigation May 3	<del>0, 2006</del>	1140 hrs	es 2 No			-					
So to be a suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number of or Town, State)								28f. Location (Street and Number or Rural Route Number, City or Town, State)						
							ierpe, MD	, MD						
29a Certifier 29a (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started one)								r as started	(-)					
4 Homicide determined (Specify) Single Family  4 Homicide 29a Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, and manner stated.  29b. Signature and title of certifier 29c. License number							u at the time, da							
	ž	29b. Signature and title of certifier			29c. License number				29d. Date signed (Month, Day, Year)					
		O.C.M.E.					1.E.		May 31, 2	31, 2006				
	30. Name and address of person who completed cause of death (Item 23a)													
6		Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201												
	State 31. Date filed (Month, Day, Year) 32. Degistrar's Signants													
Regis	trar	JUN 0 6	3 2006	ESENSO JO	1									

			For State Registrar	State of Mary		artmen <i>rtificat</i>					Reg. No.	200	6	17	788	
ting a	Physicia	an	1. Decedent's Name (First, Middle, Last)  2. Date of Month								Death 3. Time of Death Day Year				)eath	
	/Medic	_	Edward A. Walczuk June								3,	3, 2006 0845				
Examir	er	4a. Fecility Name (If not institution, give		_		ii Death		4c. County of Deeth				_				
		13	Arundel General Hospital  5. Social Security Number 6. Sex. 7. Age (In yrs. last birthday)				napol 1 Year	II Under 2		8. Date of Bird	te of Birth					
	Funeral Director		218–14–8327	M 2□F 89	Months Days Hours Min.			Min.	(Month, Da 04/22							
	p ,		Usual Residence of Decedent	10	c. City, Town or L	ocation						10d. Inside City Limits				
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	3a or		4411 Frankford A								ed St	-ata				
	death	Funeral	11. Marital Status	12. Was Decedent Eve Amed Forces?	r in U.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.				cify Yes or No		4. Race - / Black, V	America	n Indian,		
9	or Ite		1 Never Married 2 Married	1 XYes 2 ☐ No If Yes, Give Year or Dates: W		1 ☐ Yes 2 X No Specify:					1	Specify:				
IG Z IZ I D-0030 filed within 72 hours at I Hygiene. other than "natural", or rent, the Medical Exam	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	dent's Usual Occupation					16b. Kin	White 6b. Kind of Business/Industry							
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X	should be ind Menta i marked umatic ev	2	Joseph Walczuk Maryanna							na Jankiewicz						
Mar	12 sh hand 7 lsm raum		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)													
a)	is 1 and 2 should of Health and Mer- tem 27 is marke other traumatic	1 8	John Adair - Nep.  20a. Method of Disposition		20b. Place of Disp		me of			old, Ma		ation - City				
	Pages net of int: If it iry or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Specific		cemetery, cre St. Sta	niela	1110	1	06/0	9/2006	Ralt	imore	M	Maryland		
Баппто	E 40 -2	1	St. Stanislaus 06/09/2006 Baltimore, Maryland  21. Signature of Funeral Service Licensee  22. Signature of Funeral Service Licensee  David J. Weber Funeral Homes P.A.										IC.			
ă	permit. Depart Import any inj		Dariel 1	Miller		401	Ch	ester	Str	eet Bal	timo	re. N	lary	land 2	21231	
			23a. Part1. Enter the disease, or coro shock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not en	ter the mod	de of dyin	g, such as	cardiac or	respiratory a	rrest,	·	1	Approximate Interval Betw Onset and De	reen	
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Of VITAL MEC Physician: The law or this certificate has the	siciar certif irector	Be c								eath (Check only one)  Home 5 Residence 6 Other (Specify)						
	<u>σ</u> + ε	n: To	27. Manger of Death	1 Impatient 28a. Date of Injury		3 DOA 4 Nursing Hor			28d. Describe how injury occurred							
<u></u>	Attending F ir death. ector: After by the funera	atlo	→ Ratural 5 ☐ Pending (Month, Day Year) Injui 2 ☐ Accident investigation				Work? M 1 Tes 2 No			28I. Location (Street and Number or Rural Route Number, City or Town, State)						
Division	- e - c	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place ol Injury - At home, farm, street, factory, office building, etc. (Specify)						2							
2	To the Hospital or within 24 hours at To the Funeral D completely filled it		29a. Certifier ***Certifying Physician: A the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
	Hos 24 ho Fun etely f	edical	(Check only 2 Medical Examone)	niner: On the basis of ex	amination and/or in	nvestigation	n, in my o	pinion, deal	th occurre	d at the time,	date and	place, and	due to t	he cause(s)		
	To the within 2 To the complet	Med	29b. Signature and fulle of certifier 29d. Date signed (Month, Day, Year)													
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1	17		30. Name and address of person who	completed cause of deat	h (Item 23a) Type	, Print)	14	20.0	a.	/ M	x1	vid	(R	n lin-		
1			31. Date liled (Month, Day, Year)	32 Régistrar's	Signature	VICE OF	- 1 /	1000	~~			,		4, 4, 4,		
	Sta Regist		JUN 0 6 20	DS Registral's	K A	ask)	3									

				1 - For State Registrar		laryland		rtment of H			Reg. No.	006	17789
		Physici /Medio		Decedent's Name (First, Middle, Last)	KATHLE		. WES	TAWAY		2. Date of De Month JUNE		006 <sup>Year</sup>	3. Time of Death 12:45 A M
		Examir		4a. Facility Name (If not institution, give HOSPICE OF BALTIMO	RE GILCH	RIST C		TOW	r Location of Dea			4c. County of Death BALTIMORE	
		Funeral Director		5. Social Security Number 219-12-3757 6. Security Number 1 Usual Residence of Decedent	7. A	ge (In yrs. Ia 80	rst birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		1925	Place (State or Foreign RYLAND	
		the Maryland r 28a-f ehow nutified at	ō	10a. State 10b. County MD. BALTIM	ORE	10c. City,	Town or Loc		IMORE				10d. Inside City Limits 1 ☐ Yes 2 🗶 № 0
		death with the Maryland me 23a or 28a-f ehow rmaal Le notified at	Funeral Director	10e. Street and Number 217 ROBWOOD ROA	ROAD 10f. Zip Code 21222						10g. Citizen of What Country? U. S. A.		
	Maryland 21215-0036	72 hours after "netural", or ite	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	1 Never Married 2 Married 1 Yes 2			ver in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1□ Yes XX No Specify:					can Indian, etc. IITE
40			Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 11 YEARS  16a. Decedent's Usual Occ (Give kind of work dor life. DO NOT use retired to the complete of the comple					during most of wo d)	orking	16b. Kind of		siness/Industry HOME
00		s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 is marked other then other traumatic event, the Ma	To Be (	17. Father's Name (First, Middle, Last)	ENRY J.	GRIF					CHUR		
		and 2 she ealth and m 27 is m		JOHN R. WESTAWAY,			217 R	OBWOOD R		UTAL FROUTE NUMBER	MARYLAN	ID, 21	222
06	Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if item 27 ti eny injury or other tra		20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		cer	LTOP S		ORP.06-0	Date 2-2006		,MARY	LAND,21204
1-9	Ball	permit Depart Import eny in		21. Signature of Funeral Service License		RUTH)	DUI	Name and Addre	ss of Facility FUNERAL	HOME,INC	7922 • DUNDA	WISE LK, M	AVENUE D.21222
		Physician /Medical Examiner	jį	Immediate Cause (Final disease or condition resulting in death)	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  a								
hlun	8760, <	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	that initiated events								
Kar	.O. Box 6	The law requires that the death certificate be tee has been signed by the attending physicis age? should be detached for use as the but	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetel d	death 3 □ E	Ectopic pregnancy Other (specify)	,			ate of delive	ery Day Year
p &	rds/P	quires tha		Part II. Other significant conditions con	tributing to death t	but not result	ting in the und	derlying cause giv	en in Part I.	23e. Did to			ne cause of death?
LSTAWA	of Vital Records	siclen: The law requi certificate has been s rector, page 2 should	e Completed	25. Was case referred to medical							med? 2 No	Were auto prior to cor death? 1 ☐ Yes	psy findings available inpletion of cause of
Wes	Division of Vit	tending Physidath.  tor: After this the funeral di	Certification; To Bo	examiner?  1 Yes 2 No H  27. Manner of Death  1 Natural 5 Pending investigation  2 Accident investigation  3 Suicide 6 Could not be	28a. Date of Injury (Month, Date 28e. Place of In	ury 2 ay Year)	R/Outpatient 28b. Time of Injury		er: 4 🗆 Nursing H	ath Check only on dome 5 Residence 128d. Describe h	ence 6 00 ow injury occu		1) hospice
	Ö	spital or Al ours after of seral Directilled in by	al Certi	4 Homicide determined  29a. Certifier Certifying Phys	building, e	tc. (Specify)			ne date and place	City or Tow	n, State)		
		To the Hospital of within 24 hours at To the Funeral D completely filled it	Medical	(Check only 2 Medical Examirone)  29b. Signature and title of certifier	er: On the basis of and manner st	of examinatio	on and/or inve	stigation, in my o	pinion, death occu	urred at the time, o	late and place	and due to	the cause(s)
		- s + ö		30. Name and address of person who co	mpleted course of	death /ltow 1	22a) /Turn 2	D	58300	3	June	1,20	Œ
		10	·a.	31. Date filed (Month, Day, Year)	s, nn) (	ocol (Item 2		Carles	Sr BA	nuore	mo z	(202	<i>t</i>
		Sta Registr	HIN O COOCK NO. M. Acount										

		1 - For State Registrar	State o	f Maryla		irtment of it			ental H	ygie Reg.		06	17790
		1. Decedent's Name (First, Middle,	Last)						2. Date of D	eath		V	3. Time of Death
Physic /Med		Helen Mary	Wos						June	4,	<sup>Day</sup> 2006	Year	6:12a ™
Exam		4a. Facility Name (If not institution,		mber)		4b. City, Town,		of Death	th		4c. County		
		Gilchrist Hos	-			Towsor					Balti	mor	e Co.
Funera Directo		195-20-7461	5. Sex 1		last birthday) Yrs.	Months Days		24 Hrs. Min.	8. Date of E (Month, I Sept	oay Ye	1°924	Couit	otace (State or Foreign ntry) nsylvania
and		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation			-			1	0d. Inside City Limits
Mary -f ehc	tor	PA Luzern	ne Co.	Wa	namie								1 K Yes 2 No
r 28a	iec	10e. Street and Number				10f. Zip Code				10g.	Citizen of W	hat Cour	ntry?
h witi	Funeral Director	285 Vandermarl	c Road			1863	4			U	SA		
dea	ner	11. Marital Status	12. Was Deci	. Was Decedent Ever in U.S. 13. Was Armed Forces?		Vas Decedent of Hispanic Origin? (Spo Yes, specify Cuban, Mexican, Puerto		gin? (Spe	cify Yes or N	10-		- Amend	can Indian,
36 safter	y Fu	1 Never Married 2 Marrie	d 1 ☐ Yes If Yes, Gir	2 ⊠ No ve		1 ☐ Yes 2 ➡ No Specify:			, ,				
hours	ed by	3 ☑ Widowed 4 ☐ Divorced  15. Decedent's	Year or D	ates:	1Co Door					101	Specify:		
15.	Completed	(Specify only highest	grade completed)		(Give	ve kind of work done during most of working					imore City		
212 I with liene.	Eo	Etementary/Secondary (0-12)	Coltege (	1-4or 5+)	Cleri							lice Dept.	
ind 21215-0036 be filed within 72 hours after death with the Maryland tall Hygiene. d other then "natural", or items 23s or 28s-f show event, the Medical Examinal must be notilled at	BeC	17. Father's Name (First, Middle, La	•				18. Mothe	er's Name	(First, Middl				
vid be	ToB	John Tillets	ci				Mary	y El	iash				
faryla 2 should and Men 16 marks		19a. Informant's Name/Relationshi	p (Type, Print)		19b. Maitin	g Address (Stree	t and Numbe	er or Rura	l Route Num	ber, Ci	ty or Town, S	State, Zip	Code)
and and m 27		Edward Wos- Sc	n		3801	Jarret	tsvil	lle	Pike	Mad	donna	. M	21084
More Pages 1 nent of H nnt: if Ne		20a. Method of Disposition 1   Burial 2 □ Cremation 3	B □Removal from	State 20b.	Place of Dispo- cemetery, cren	sition (Name of natory or other pla		5 – 7 <b>–</b>	ate	20c	. Location - (	City or To	own, State
timen timen tuent:		4 ☐ Donation 5 ☐ Other (Spe	ecify)		cred I	Heart of Mary Com Dune					undal		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examinar must be notified at		21. Signature of Funeral Service Li	censee		22	Name and Addr	ess of Facilit	<sup>y</sup> Kac	zorow	sk	i Fun	era	l Home, P
_ 48244		23a. Part1. Enter the disease, or or	amplications that a	ausad the des		<u>'Ul Dun</u>	dalk	Ave	. Bal	tir	nore,	_MD	21222 Approximate
		shock, or heart failure. List or	nly one cause on e	ach line.	itii. Do not ente	er the mode or dy	ing, such as	cardiac of	respiratory	arrest,			Interval Between Onset and Death
Physician /Medica		disease or condition resulting in death)		rain .									Days
Examine			Due to	(or as a conse	quence of):								
, 3	ē	Sequentially list conditions, it any leading to immediate	b. Due to	or as a cons	cuence of):								
in the design of the series of	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
60, 60 be executed burial-transit	EX	resulting in death) Last	Due to	(or as a conse	quence of):								
8760, cate be en	dical		d		· · · · · · · · · · · · · · · · · · ·								
K 68	Med	IF FEMALE:											
Records, P.O. Box 68760, ~ The law requires that the death certificate be executed that she bear signed by the attending physicien and large 2 should be detached for use as the burial-transia	by Physician/Me	23b. Was decedent pregnant in the past 12 months?		irth 2 ☐ Fet	al death 3	Ectopic pregnanc	y				23d. Date Mont		ry Day Year
9 g gg	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregn 9□ Unkno	ant at time of	death 5∐	Other (specify) _							7.02.
S, P.C	Ph	Part II. Other significant condition	s contributing to de	eath but not re	sulting in the ur	deriving cause or	ven in Part I.		23e. Did	tobaco	o use contril	oute to th	e cause of death?
ds, de la signa de	d b				-	, , ,			1 🗆	Yes	2 □ No 3	3 ☐ Prob	abty 4 Unknown
Cord Cord W requir	Completed						•	_	24a. Wa	e an	24b W	oro auto	ney findings available
Recommendation of the law	E G								auto	ormed	? de	ath?	psy findings available appletion of cause of
- d c	0	25. Was case referred to medical					26 Place	of Doath	1 Yes	200	No 1[	Yes	2) 10
	To B	examiner? 1 🗌 Yes 2 🗹 No	Hospital:	Inpatient 2	] ER/Outpatien	3□ DOA Ot					6 Other	(Specifi	hospice
- O E = E	Į.	27. Manner of Death	28a. Date	of Injury th, Day Year)	28b. Time of	28c. Inju	ry at	2	8d. Describe	how in	itury occurre	d	, cospice
Oivision or Attending after death. Director: After	Certification;	1 ☑Natural 5 ☐ Pending investiga	tion	,,	in(dry		Yes 2 □ !	No					
Or Atten	tific	3 Suicide 6 Could no 4 Homicide determin	289. Place	of Injury - At I	nome, farm, stre	et, factory, office		2	8f. Location City or To	(Street	and Number	r or Rura	Route Number,
ours ell		V											<u> </u>
DIVISIC DIVISION To the Hospital or Attent within 24 hours eiter deati To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physicien: To the caminer: On the ba	best of my kn asis of examin ner stated.	owledge, death ation and/or inv	occurred at the to estigation, in my	me, date and opinion, deat	d place, a th occurre	nd due to the d at the time	cause , date a	e(s) and man and place, ar	ner as st nd due to	ated. the cause(s)
To the Hose within 24 hor To the Fun	Med	29b. Signature and titte of certifier	and man	ner stateg.		29c. Licen	se number			29d. i	Date signed	(Month )	Oav. Yearl
F 3 F 8		Mona	0					07					
j,		30. Name and address of person wi	no completed caus	e of death (tre	m 23a) (Tyne I	Print)					100		
N		AARON CHAM	141 000	6601	N.C	Landas	St 13	BALM	more	M	212	24	
s	tate	31. Date filed (Month, Day, Year)	32. R	egistrar's Sign	atur	,							
Regis		JUN 0 6 2006	BE 4 . A .	A 6.1	AND A								

06-03806 Gulcan Yildirin

# Please Type or Print in Black Indelible Ink

	- For State - For State - Registrar - For State - Certificate of Death	Reg. N	200	6 1779					
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)	Date of Death Month Day June 4, 2006	Year	3. Time of Death 0340 hrs					
	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Death						
	Shady Grove Hospital Rockville		Montgomery						
Funeral Director	220-53-2724 1 M 2 XF 24 Yrs. Months Days Hours Min.	Feb. 27,	M/DD/YYYY) 9 Bir Foreig 1982 Co						
auò	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits					
laryland 8a-f show at once.	Maryland Montgomery Germantown		itizen of What Cou	1 Yes 2 X No					
th the Maryland 23a or 28a-f show notified at once.	10e. Street and Number 10f. Zip Code 13420 Daventry Way Apt. 1 20874	, i	J.S.A.	itr <b>y</b> 2					
	11. Marital Status 12. Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Spec	cify Yes or No-		can Indian, Black,					
er death with , or items 23 r must be no	1 Yes 2 X No	341, 3.3.)		White					
urs afte ntural" amine d by	15. Decedent's Education (Specify only highest grade completed)  16a Decedent's Usual Occupation (Give kind of wor		. Kind of Business/l						
215-0036 be filed within 72 hours after ntal Hygiene ntan "natural", ent, the Medical Examiner Be Completed by	Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)	1)	Corromon						
21215-0036 ould be filed within 7 amarked other than it event, the Medica To Be Comple	2 Shipping Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (F	First, Middle, Maide	Governmen  en Surname)	nt					
215 be filed ntal Hy riked o ent, th	Mehmet Cavit Yildirim Ayse Fat								
ID 21 t should and Me t7 is man natic ev	19a. Informant's Name/Relationship (Type, Print)  Canan Sik (Sister)  19b. Mailing Address (Street and Number or Rur  14400 Rim Fire Ct., Bo			, Zip Code)					
e, MD 21  I and 2 should Health and Me 'item 27 is ma r'traumatic e.	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	- T	Location - City or	Town, State					
Baltimore, pernit Pages I ar Department of He Important: If it important: If it injury or other tr	1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify Gaziantep Cemetery June	8,2006	Siziantep	, Turkey					
Baltir permit Departm Importa	4 / Serialist S Street Speeding								
Physician	251 Deka1b Ave. Br. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or not enter the mode of dying, such as cardiac or not enter the mode of dying.	rooklyn.	NY 11205 hock, or heart	Approximate Interval					
/Medical	failure. List only one cause on each line.  Immediate Cause (Final disease a Cocaine intoxication			Between Onset and Death					
Examiner	or condition resulting in death)  Due to (or as a consequence of):								
ler	Sequentially list conditions, if any, leading to immediate bulleto (or as a consequence of):								
ted 1 Insit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last  Due to (or as a consequence of):								
760, icate be executed physician and the burial - transit	d								
'60, zate be execut physician and he burial - tra	X UNPENDED item#23a,27,28a-f,perME,g856,6/15/06		23d Date of deliver	,					
5876 rrtificat fing ph s as the	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnance			Day Year					
Sox 687 leath certific e attending p for use as th	1 Yes 2 No 9 ✓ Unknown 9 Unknown			9					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitedical Certification: To Be Completed by Physician/Medical Eigelical Certification:	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			the cause of death?					
s, P.( uires that n signed ld be deti		1 Yes 2		oably 4  Unknown					
Records, The law requires ficate has been signed. Page 2 should be Completed		autopsy performed	prior to	completion of cause of					
I Rec	25. Was case referred to medical 26. Place of Death (Check on		No 1 Y	es 2 No					
Vital tysician this cert directo	evaminer?		dence 6 Othe	r:					
After t funeral	(Month, Day, Year)	8d. Describe how	injury occurred						
ivisior  or Attend after death Director: d in by the	Investigation Find 6/4/2006 [Find 3:30 am ] X 1	unk 18f. Location (Stree	t and Number or Ru	ıral <u>Ro</u> ute Number, C <u>it</u> y					
Division o spital or Attending nours after death neral Director: Afti filled in by the func Certification:	3 Suicide 6 X Could not be determined (Specify) found at home	or Town, State;	MD Daventi	ral Route Number, City Cy Way, Apt I					
D To the Hospital within 24 hours To the Funeral completely filled	29a Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and done) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time.								
To the Howithin 24 To the Fu Completel	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at a and manner stated  29b. Signature and title of certifies  29c. License number		d Date signed (Mo						
- x	O.C.M.E.	Ju	ine 4, 2006						
10%	30. Name and address of person who completed cause of death (Item 23a)	201							
State	Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 212  31. Date filed (Month, Day, Year)  32. Registrar's Signature	.01							
Registra	11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1								

State of Maryland / Department of Health and Mental Hygiene ?

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				(	Certificate of	Death	R	eg. No.	00	11170			
	Discolution	1. Decedent's Name (First, Middle					2. Date of Deet Month		Vear	3. Time of Death			
The same	Physician /Medical	Willette	A1	ston			May	14" 2	006	10:20PM			
	Examiner	4e Fecility Neme (If not institution,	-			4b. City, Town, or Loc		4c. County	of Death				
		Gladys Spellman				Chever1		Prince	Geo	ges			
	Funeral Director	579-76-1666	6. Sex 7. Age (I	n yrs. lest birth	Months Days		8. Date of Birth (Month, Dey, Lugust 2	26,1965	9. Birthp Coun Wash	lace (Stete or Foreign try) Ington, DC			
	pue *	Usuel Residence of Decedent  10a. Stete 10b. County	10	Oc. City, Town	or Location				10	0d. Inside City Limits			
	vith the Maryk or 28a-f sho be northed a	MD Prince	Georges	•	ol Heights	1				1KD Yes 2 □ No			
	23a or 2	10e. Street end Number 6711 Blacklog	Street		10f. Zip Code 20743		1	10g. Citizen of What Country?  USA					
020	permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Deperment of Health end Mentel Hygiene. Deperment of Health end Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show surportant: If Item 27 is marked other than "natural", or items 23a or 28a-f show important: If Item 27 is marked or 1 in Maryland and 1 in Maryl	11. Marital Status  1 □ Never Married 2 Amarrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ♣ No If Yes, Give Year or Detes:	or in U,S.	13. Was Decedent of If Yes, specify Cub.  1 Yes 2 No		cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black					
5-0	led within 72 ho ygiene. Per than "natura nt, the Medical I	15. Decedent's (Specify only highest		16a. Decedent's Usual Occupation (Give kind of work done during most of work)			ing 16b. Kind of Business/Industry			lustry			
121	Althin ne.	Elementary/Secondary (0-12)	College (1-4or 5+)	7	ife. DO NOT use retire	nd)		Priva	<b>.</b> .				
2	Part CO	17. Father's Neme (First, Middle, L	oatl	Se	curity Gua	18. Mother's Name	/First Middle A						
Baltimore, Maryland 21215-0020	Mentel H Mentel H arked ott artic ever	Unknown	esi/			Delorse		loore	ie <i>)</i>				
Man	ith end I	19a. Informant's Name/Relationsh Larry Alston/Hus			Mailing Address (Street			; City or Town, <b>20706</b>	State, Zip	Code)			
re,	of Heal	20a. Method of Disposition		20b. Place of D	Disposition (Name of crematory or other pla	1	ACAD STATE	20c. Location -	City or To	wn, State			
Ē	Pege ment c ant: If ury or	1 ABurial 2 ☐ Cremation : 4 ☐ Donation 5 ☐ Other (Spi			y Cemetery	5/	24/2006		-				
3alt	Depenting Indiana in I	21. Signature of Funeral Service L	icensee			ess of Facility $\mathbf{J}_{ullet}\mathbf{B}$			eral i	Home			
_	40.5 4 4	K. D. H-	-hall			over Rd., I		-	2078	:5			
		23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that caused the nly one cause on each line.	e deeth. Do no	t enter the mode of dyi	ng, such as cardiac or	respiratory arre	est,		Approximate Interval Between			
7	Physician /Medical	Immediate Cause (Final		1.0						Onset and Death			
	Examiner	disease or condition resulting in death)	isease or condition CETVICAL CARCINOMA										
	je je		Du	e to (or as a co	nsequence of):								
60,	The law requires that the death certificate be executed are hes been signed by the ettending physician end page 2 should be deteched for use as the buriel-transit Completed by Physician/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events	b. Due	e to (or as a co	nsequence of):								
ox 68760,	T >	Due to (or as e consequence of):  d											
B	death	Part II. Other significent condition	s contributing to death but n	ot resulting in t	he underlying cause gi	ven in Part I.	23b. Did to	becco use cor	ntribute to	the cause of death?			
P.O. B	at the stock the	Respiratory Fa					1 □ Y	s 2 No	3 Prob	ably 4 Unknown			
ń	es the signed be d				oopna_opaci		-						
Vital Records,	: The law requires that the death or sele has been signed by the ettend pege 2 should be deteched for us.  Completed by Physician/						24a. Was ar perform	n autopsy ned?	ava	re autopsy findings ilable prior to npletion of cause leath?			
ž	The la						13 Ye	s ak Nu	1 🗆	Yes 2 No			
	entifice actor, p	25. Was case referred to medical examiner?				26. Place of Death	(Check only on	e)					
<u>&gt;</u>	Physician: rthis certific ral director, r: To Be (	1 ☐ Yes 2 ♣ No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outp	atient 3 DOA Oth	ner: 4 🗷 Nursing Hom	e 5□ Reside	nce 6 DOth	er (Specify	)			
ono	th.: After the funera	27. Menner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Injury (Month, Dey Ye	28b. Tin Inju	ıry Wo	ryat 25 rk? IYes 2 □ No	8d. Describe ho	w injury occurr	ed				
Division of	tal or Attending P rs efter death. al Diractor: After t led in by the funera Certification:	3 ☐ Suicide 6 ☐ Could no determin	28e. Place of Injury building, etc. (S	- At home, farm Specify)	, street, factory, office	28	8f. Location (Sti City or Town	reet and Numb , Stete)	er or Rurel	Route Number,			
	To the Hospital or Attending Physician: The law require within 24 hours effect death.  On the Funeral Director, After this certificate has been significately filled in by the funeral director, page 2 should Medical Certification: To Be Completed		Physician: To the best of m	eminetion end/									
	o the o the omple	29b. Signature and title of certifier	end menner stated	•	29c. Licens	se number	29	9d. Date signed	(Month, E	Dey, Yeer)			
	F 3 F ő	1 4.7. M	& mo		D002	26024		May 17	, 200	)6			
1)	$\mathcal{A}$	30. Neme and eddress of person w				_			, 400				
	CIVI	Lester Miles, N 31. Date filed (Month, Day, Year)		over Rd	, Suite F,	Landover,	MD 20	785					
	State Registrar	MAY 2 2 200	32. Registrer's	& Age	uli)								

State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 05 **Physician** Antoinette S. Arakelian 17 2006 5:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1232 S Ritchie Highway Arno1d Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month Day Year 05/01/1910 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Funeral Months Days Hours 1 ☐ M 2 🕅 F Turkey Yrs 96 110-12-2438 Director Usual Residence of Decedent deeth with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 X Yes 2 ☐ No Director Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 United States 7 Thompson Street by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. e filed within 72 hours after of Hygiene.
I Hygiene.
othar than "natural", or Itar 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 end 2 should be file.
Department of Heelth and Mental Hyg Important: If Item 27 is marked other any Injury or other traument. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Onnig Sudbeazian Catherine Nourikhanian ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Thompson St. Annapolis, Maryland 21401 Louise A. Raphael (daughter) 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Metropolitan Crematory May 18, 1 Burial 2 Cremation 3 Removal from State Alexandria VA 4 ☐ Donation 5 ☐ Other (Specify) 2006 22 Name and Address of Facility Advent Funeral and Cremation Services 21. Signature of Funeral Service Licenshe Morrely Falls Church and Annapolis 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** morth /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the signed by the attending I be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ page 2 should be 2 10 No 1 ☐ Yes 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 2 No 1 Yes 2 NO 1 TYes or Attending Physicien: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) ther (Specify) 1 Yes 2 No Certification: To -1 VING 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Natural investigation М 1 □ Yes 2 □ No 2 Accident hours efter deat uneral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours eff To the Funeral Di completely filled in To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified of death (Item 23a) (Type Print) egistrar's Signature 31. Date filed (Month State Registrar

			Please  1 - For State Registrar			nd / Depa		C. Ensure All Health and M Death	lental Hygie	_	5 17791
	hysicia /Medic		Decedent's Name (First, Middle, Learning Charles Allen	ast)					2. Date of Death Month	Pay Acol	3. Time of Death  2:00 A <sup>M</sup>
	xamin		4a. Facility Name (If not institution, g	ive street and numb	per)		4b. Cily, Town,	or Location of Death	0	4c. County of Dea	
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36 C	or it	y Fu	1 Never Married 2 Marned	Amed Force 1 XYes 2 tf Yes, Give	□ No T J	72	1 □ Yes 2X No		indan, otc.)	Specify:	
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	5 to 1		William Allum/Bro	other				reek, Seaf			
- P - E	rothe		20a. Method of Disposition	7.0	20b.	Place of Dispo	sition (Name of natory or other pla	ace)		Location - City or	
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alt.	any injury once.	- 1	21. Signature > Funeral Service Lic	milee /	M			ess of Facility neral Home			
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		j,	30. Name and address of person who WILLIAM ROBINS, M					, MD. 218	04	6	
PA	∗ Stat		31. Date fited (Month, Day, Year)		strar's Sign			, LID. 710	U-1		
B.	egistra	· 1	MAY 2	2 2006	20	M	Annally 1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MAY 24, <sup>Day</sup> 2006 Year MARY ELIZABETH ANDERSON 22:50 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 919 MEADOWVIEW DRIVE CHESTERTOWN KENT 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 77 A **Funeral** 1 ☐ M 2 🂢 F 74 224-44-4345 VA Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow injury or other traumatic event, the Medical Examiner must be notified at KENT CHESTERTOWN Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 919 MEADOWVIEW DRIVE 21620 USA Iteme 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Pages 1 end 2 should be filed within 72 hours after 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or WHITE 1 Yes 2 No Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Health and Mental Hygiene. em 27 le marked other then Elementary/Secondary (0-12) College (1-4or 5+) REGISTERED NURSE HEALTH CARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LOREN ANDERSON NETTIE DUNGAN ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2
Department of Health as
Important: If item 27 ie
eny injury or other trau LOREN HENRY ANDERSON/BROTHER 919 MEADOWVIEW DRIVE, CHESTERTOWN, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State OAKLAND UMC CEMETERY 05/31/2006 FERNHAM, VA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME
130 SPEER ROAD, CHESTERTOWN, MD 21620 21. Signature of Funeral Service Licensee ups or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part1. Enter the disease, or comshock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CHOLANGIO CARCINOMA disease or condition resulting in death) YETARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physicien a for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🔼 40 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Tes 2 No 3 Probably 4 Nonknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? rectificate has lirector, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2. No 25. Was case referred to medical examiner? director Be 26. Place of Death | Check only one Hospital: 1 | Inpatient Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 1 ☐ Yes 2 No မှ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Oate of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1. Natural Injury 5 Pending death 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a

To the Funeral C

completely filled 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 2005 7509 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHESTERTOWN MD 21620 MASHINGTON AVE VAMES LACEY, MO 516 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 2 6 2006 DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1- State Amend Item 26 per Verb., G856, 06/06/26 bb Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 05 Physician Lonnie David Athey /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13712 Cardinal Drive SE Cumberland Allegany If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Jun'3, 1959 9. Birthplace (State or Foreign **Funeral** 1 ☑ M 2 ☐ F (VICY) 46 213-84-5287 Yrs Director Usual Residence of Decedent with the Maryland Town or Location Cumberland 10c. City, 10d. Inside City Limits other then "natural", or items 23a or 28a-f show vent, the Modical Examinar must be notified all MD Allegany Director 1 □X es 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21502 USA 13712 Cardinal Drive SE by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: white 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Athey's Medical Supply owner permit. Pages 1 and 2 should be filed v Depertment of Heelth and Mental Hygien Important: If item 27 is marked other tt any Injury or other treumatic event, IIIs ance. 18. Mother's Name (First, Middle, Maiden Surname)
Dixie L. Klosterman Athey 17. Father's Name (First, Middle, Last) Edward C. Athey, Sr. ဂ္ a Informant's Name/Relationship (Type, Print) wife 199 Nailing Address (Sign) and Humber of Part House Number City of John, State, Zinnig 21502 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Davis Memorial Cemetery 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 5/27/2006 Cumberland MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service 22. NamScarpellis Furreral Home, P.A. 108 Virginia Avenue: Cumberland, MD 21502 and / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last onsequerce of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 58760, Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 3 Probably 4 Unknown 2 500 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an 1 Yes 2**√2**′No nerel Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 13601 30. Name and address of person who completed cause of death (Item 23a) (Type, 925 Bishop Walsh Drive Cumberland MD 21502 V Felipa M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 0 6 2006

ORIGINAL

			1- State Registrar Amend #20b	State of M Per FH G	laryland / 856 6/06	Depa	artment of H rtifjgate of L	ealth and Death	d Mental Hy	giene 200	6 17797
	Physici	an	1. Decedent's Name (First, Middle, Last)  Mary Arlo						2. Date of De.	ath Day Yes	
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			Ft. Washington Hos  5. Social Security Number 6. Sex	·	ge (In yrs. last b	inth days)	Ft. Wash		ke la Day (Bid	Prince	
Н	Funeral Director			M 2 <b>X</b> ) F	83	Yrs.	Months Days	Hours M	irs. 8. Date of Bird in. (Month, Da July 15	y, Year) 1922 Mi	Birthplace (State or Foreign Country) Chigan
	/land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	wn or Lo	cation				10d. Inside City Limits
	Ba-f sh	ctor	Maryland Charles		l w	la 1 d	orf				1 ☐ Yes 2X No
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	ems 2	ınera	903 Copley Avenue	12. Was Deceden Armed Forces	t Ever in U.S.	13.			(Specify Yes or No- erto Rican, etc.)		merican Indian,
38	within 72 hours after death with the Maryland ene. than 'natural', or Items 23a or 28a-1 show ha Madical Examainer unter be notified at	by Fu	1 Never Married 2 Married 3 Widowed 4 🗷 Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	No		I□Yes Ž∷No	Specify:		Specify:	White
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bug	be file ntat Hyg od othe event,	Be	17. Father's Name (First, Middle, Last)					18. Mother's N	lame (First, Middle,	Maiden Sumame)	· · workuging
Maryland	cate be executed S S S S S S S S S S S S S S S S S S S	J.	Winfred Pierce  19a. Informant's Name/Relationship (Ty)	oe, Print)	191	b. Mailin	g Address (Street a		rtha Broo	OKS or, City or Town, State	, Zip Code)
			Mark Boland - Son		9	03 (	Copley Ave		aldorf, M		
nore			20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemete	ery, cren	sition (Name of natory or other place e Cemeter)		Date 25/2006	20c. Location - City	or Town, State , Michigan
Baltimore,			21. Signature of Euneral Service License	<u> </u>		_	. Name and Address		E	old Washing	
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	Physician		shock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each	Coma	not ont	or the mode of dying	, such as card	ac or respiratory ar	rest,	Interval Between Onset and Death
			resulting in death)		s a consequence	2	`				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence	ne,	nig				
	and I-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence	of):					
8760,	ysician	dicalE				J.,.					
	ding ph	/Med	IF FEMALE:	to If was autoam	of programme.						
P.O. Box	ires that the death certifi signed by the ettending I be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant a	2 Petal death t time of death		Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
P. 0.	hat the od by th detache	Phys	9 ☐ Unknown  Part II, Other significant conditions continued to the significant conditions	9□ Unknown	out not resulting	a the un	dorhving oguso gwor	n in Boot I	22a Did ta	hages use seetablete	to the cause of death?
rds,	w requires been signe should be	ed by	Urinay	- 1	sted-	TO COLO	g cause give				Probably 4 Unknown
eco	e taw re has bee	Completed	multi	infect	afennati	r e <sub>i</sub>			24a. Was a	an 24b. Were a	autopsy findings available o completion of cause of
Division of Vital Records,	ician: The Certificate harector, page		25. Was case referred to medical	V		_				2 No 1 Ye	
<u>&gt;</u>	Physician: this certific ral director,	To Be	examiner? 1 ☐ Yes 2 ☑ No Ho	spital: 1 Inpati	ent 2□ER/O	ztpatient	Othor		eath <i>Check only or</i> Home 5 Reside	ence 6 □Other (Sp	ecify)
olo	ding P th. After t funera	Certification;	27. Manner of Death 1 □Matural 5 □ Pending 2 □ Accident investigation	28a. Date of Inju (Month, Da		Time of Injury	28c. Injury : Work? M 1 7	at es 2 □ No	28d. Describe ho	ow injury occurred	
N N	l or Attendate after death Director:	tifica	3 Suicide 6 Could not be determined	28e. Place of In	jury - At home, fa	arm, stre			28f. Location (Si City or Town	treet and Number or F	Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  Yet have ranger deter death.  To tha Funaral Director: After this certificate has been signed by the ettending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Cartifying Physic	cian: To the best	of my knowledge	n death	occurred at the time	date and play			
	the Ho in 24 h tha Fur ipletely	ledical	one)	ar: On the basis of and manner st	it examination an	d/or inv	estigation, in my opi	nion, death occ	curred at the time, d	ate and place, and du	ue to the cause(s)
	With To To	Σ	29b. Signature and title of certifier	Million C			29c. License			9d. Date signed (Mor	
1			30. Name and address of person who cor	npleted cause of	death (Item 23a)	(Type, F	Print)	ال ساء		5/22/06	0
.1	DO Star	0	30. Name and address of person who con hos row Dovac 31. Date filed (Month, Day, Year)  MAY 2 3	hi wo	1328	. 5	buthers	Ave	SE #31	o Washing'	ON DC 20032
	Registra		MAY 2 3	SOUR NO	eve &	1	barte			9	

			1 - For State Registrar	te of Maryland / De	epartment of F Certificate of		nd Mental Hy	giene Reg. No.	2006	17799	
	o .		1. Decedent's Name (First, Middle, Last)				2. Date of D	eath Day	Year	3. Time of Death	
	Physici /Medic		ROBERT LEE	BRITTINGHAM			May	16,	2006	1824 PM <sup>M</sup>	
	Examir		4a. Facility Name (If not institution, give street a	nd number)	4b. City, Town, o	r Location of	Death	4c. 0	County of Death		
	7		10448 Pidgeon Lane		Princes				omerset		
	Funeral Director		5. Social Security Number 6. Sex 1213-22-9159	7. Age (In yrs. last birtho	Months Davs	Hours	Min. 8. Date of B (Month, D Oct. 3	av Year)	Cou	place (State or Foreign intry) 'Y Land	
	pu ,		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town o	. Location					10d. Inside City Limits	
	aryla shov	-								1 ☐ Yes 2 No	
	Me M	ecto	Maryland Somerset  10e. Street and Number	Princes	SS Anne			10a Citiz	en of What Cou		
	with t	Ē	10448 Pidgeon Lane		2185	: 2		_	U.S.	ntu y r	
	s 23	era		s Decedent Ever in U.S.			n? (Specify Yes or N		4. Race - Ameri	can Indian	
36	gas 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other then "neturel", or Items 23a or 28a-1 show or other treumatic event, the Medical Examinar must be notified at	by Funeral Director	1 Never Married 2 Married	ned Forces? ]Yes 2 □ No es, Give ar or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	Specify:	Puerto Rican, etc.)		Black, White, Specify: Whi	etc.	
21215-0036	e hou	ed	15. Decedent's Education	16a. Do	ecedent's Usual Occup	ation		16b. Kin	d of Business/In		
:15	nin 72 n "ne	Completed	(Specify only highest grade comp	leted) (C lin	Give kind of work done fe. DO NOT use retired	during most o d)	of working			,	
212	d with giene ir the	mo;	12 no	-	Truck Driv	er		Tran	sportat	ion	
b	2 should be filed withir and Mental Hygiene. Is marked othar then eumatic event, It e Ms	Be C	17. Father's Name (First, Middle, Last)			18. Mother's	s Nam <i>e (First, Middle</i>	e, Maiden S	Sumame)		
Maryland	should bind Ments marked	70	Noah James Britting	gham		Dais	y Hender	son			
an	and I		19a. Informant's Name/Relationship (Type, Pri	nt) 19b. N	lailing Address (Street	and Number	or Rural Route Numi	ber, City or	Town, State, Zij	p Code)	
	1 and 3 Health em 27 ther tr		Jean C. Brittingham/		448 Pidgeor						
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Remova	20b. Place of D cemetery,	isposition (Name of crematory or other place	ce)	Date	20c. Loc	ation - City or To	own, State	
Ë	Pa me me me me me me me me me me me me me		`4 □ Donation 5 □ Other (Specify)	Salisbu	ıry Cremato		5/18/2006	Sali	sbury,	Md.	
Baltimore,	permit. Departr Importe eny inju		21. Signature of Funeral Service Licensee	/ MOO295	22. Name and Addre		minan r			Md. 21853	
			23a Jart1. Enter the disease, or complication	That caused the death. Do not					s Allile,	Approximate	
	Pnysician /Medical		Shock, or heart failure. List only one cause finediate Cause (Final lisease or condition resulting in death)	on each line.	UN SHOT	IN	JURY			Interval Between Onset and Death	
	Examiner			rub to (or as a consequence or)	•						
		ĕ		oue to (or as a consequence of)	:						
	cuted Id ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
ó	sician and burial-transit	EX	resulting in death) Last	Due to (or as a consequence of).	:						
8760,	ate be ex hysician the buria	Icai	d								
9	e as t	Med	IF FEMALE:								
O. Box	The law requires that the death certiticate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medicai	in the past 12 months?	es, outcome of pregnancy ]Live birth 2 □ Fetal death ]Pregnant at time of death ]Unknown	3 □Ectopic pregnancy 5 □ Other (specify) _	<i>,</i>		23	3d. Date of delive Month	ery Day Year	
P.0	that the design of the design		Part II. Other significant conditions contribution	ng to death but not resulting in th	ne underlying cause giv	en in Part I.	23e. Did	tobacco us	e contribute to t	he cause of death?	
rds	quires n sign uld be	ed by					1 🗆	Yes 2□	No 3□Prot	bably 4 Unknown	
000	aw raquin s baen si s should l	Completed					24a. Wa		24b. Were auto	ppsy findings available	
Re	sician: The law s certiticate has b lirector, page 2 s	шо					peri	opsy ormed? 20 No	death?	ompletion of cause of	
ita		a	25. Was case referred to medical			26. Place 0	of Death (Check only				
<b>/</b>	Physician: this certition ral director,	To B	examiner? 1°X Yes 2 ☐ No Hospita	: 1 ☐ Inpatient 2 ☐ ER/Outpa	atient 3 DOA Oth	er: 4 ☐ Nurs	ing Home 5 Res	idence 6	Other (Specia	fy)	
0	ding Ph h. After th funeral			Date of Injury 28b. Tim (M. nth, ay Year) Inju		y at	28d. Describe			11.20	
<u>10</u>	Attending r death. actor: After by the fune	atlo	2 Accident investigation			Yes 2 No	GUN	SHOT	t To	HEAD.	
Division of Vital Records,	after de Diracto	Certification:	3 Suicide 6 Could not be 4 ☐ Homicide determined 28e	. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office			28f. Location (Street and Number or Rural Route Number, City or Town, State) 10448 PLDS BON LANE PA, M			
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funerel Diractor: After this certific completely tilled in by the funeral director.	edical C	(Check only 2 Medical Examiner: O	To the best of my knowledge, on the basis of examination and/of manner stated.	death occurred at the tir or investigation, in my o	me, date and opinion, death	place, and due to the	e cause(s) a	and manner as s	stated.	
	ro th within ro th	Me	29b. Signature and title of certifier		29c. Licens				signed (Month,		
			) U V	+9	J	) 48U	98	5	17/20	26	
_			01 113111	ARU MBUNATH	(AN) 20	1 HAL	L HIGHE	UNY	CRISE	UL IELD MD2181	
2.4	Sta , Regista		31. Date filed (Month, Day, Year)  MAY 1 9 2006	32. Registrar's Signature	fords.						

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State of Maryland / Department of Health and Mental Hygiene 006 Certificate of Death

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		•	For State Registrar	State of Maryland		tificate o			Reg. No.	06	17800
ı	Physici		Decedent's Name (First, Middle, Last     DELIA ELIZABETH BA					2. Date of De May		2 <b>Ŏ</b> O6	3. Time of Death 3:28 A M
	/Medic Examin		4a. Facility Name (If not institution, give SOUTHERN MARYLAND		ER	4b. City, Town	, or Location of De	eath	4c. County		RGES
	Funeral Director		5. Social Security Number 6. Se			If Under 1 Year Months Day			24,1936	9. Birthpl MARY	ace (State or Foreign
	death with the Maryland time 23a or 28a-f show in must be notified at	ctor	Usual Residence of Decedent		, Town or Loc					10	Od. Inside City Limits  1 Yes 2 No
	h with the	ai Dire	10e. Street and Number 1002 SHELBY DRIVE			10f. Zip Code 2074.			10g. Citizen of UNITED		•
2-0030	hin 72 hours after death with the Marylar e. en "neturel", or iteme 23a or 28a-f ehow Medical Examinat must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 MWidowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Vas Decedent o Yes, specify Co		(Specify Yes or No erto Rican, etc.)	14. Rad Bla Specif	ce - America ck, White, e	etc.
0-017	within 72 hours after ene. then "neturel", or ite	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation de completed) College (1-4or 5+)	(Give ) life. D		ne during most of v ired)		16b. Kind of B		ustry VDUSTRY
yland z I	al Hygi d other	Be	6TH GRADE  17. Father's Name (First, Middle, Last)  JOHN BENJAMTN BAR	OII GMADE							
Maryis	2 should to and Ment is marked sumatice	P	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town								Code)
	s 1 and 2 if Heelth item 27 i		KATIE DUCKETT / D.  20a. Method of Disposition	AUGHTER 20b. PI		SHELBY sition (Name of patory or other p		KON HILL,	MARYLAI 20c. Location		0745 wn, State
pallimore,	Pages nent of ant; if it		1 Bunal 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	-	S CHURCH		MY 25,2006		,	ARYLAND
Dall	permit. Pages 1 Depertment of H Important; if ite eny injury or ot once.		21. Structure of Funeral Service Constitution C. THORNION	THINKON MOOS83	11	Name and Add	UNERAL HOM	E, P.A. INDIAN HE	AT) MATRO	ANTO 20	0640
68760,	hilicate be executed by American and physicien and as the burial-transit	edical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence.  Due to (or as a consequence.  Due to (or as a consequence.  Due to (or as a consequence.	ience of):	191	Ful u		rrest,		Approximate Interval Between Onset and Death
O. Box 6	ath cer ettendir for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnal Other (specify)				ite of deliver	y Day Year
7	wrequires thet the de been signed by the s should be detached	۵	Part II. Other significant conditions co	ontributing to death but not resu	Iting in the un	derlying cause	given in Part I.				e cause of death?
II Kecoras,	The lay ete hes page 2	Completed						24a. Was autoj perfo	rmed?	death?	sy findings available apletion of cause of
VItal	Physician: this certific al director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 1	ER/Outpatien	2CI DOA   C		Death (Check only only only only only only only only			
lon or	ding After funer	<b>-</b>	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. In	jury at fork?		how injury occur		)
DIVISION	2552	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Roccity or Town, State)								
	전 4 분 등	Medical	29a. Certifier 1 ☐ Certifying Phy (Check only one)	rsician: To the best of my know iner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the estigation, in m	time, date and play y opinion, death of	ace, and due to the courred at the time,	cause(s) and ma date and place,	anner as sta and due to	ated. the cause(s)
	To the To the Complet	Me	29b. Signature and title of certifier	16.410			ense number	2	29d. Date signe	_	
,			S.0100,	ILVVV			0553	214	05.19	1.0	006

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)
MAY 2 2 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) I LL RD, SIESOF, OKON 1414, MD 20745

State of Marylan	d / Department of Health a	and Mental Hygiene 🛚 🗍 🗍

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<b>Physician</b>
/Medical
Examiner
LAGIIIII

For

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event. The Medical Ever in serminal be netitived in once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed

1. Decedent's Nam					tificate of i				Reg. N			
- Facility Manne (	e (First, Middle	e, Last)						2. Date of Do		av	Year	3. Time of Death
- Paulika Nama /		Emma	Beatrice	e Butle	er			May	1	7, 2	006	9:10A
a. racility Name (	If not institution	n, give street and nu	umber)		4b. City, Town, o	r Location	of Death		4	c. County	of Death	
Mallard	Nursi	ng Home			Cambrid	ge				Dor	chest	ter
5. Social Security N	lumber	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under		8. Date of Bi	rth	an).	9. Birthp	place (State or Foreigntry)
219-03	-5528	1□M 2□F	100	Yrs.	Months Days	Hours	Min.	(Month, D	$\overset{\text{ay, rea}}{4}$	″1906	Air	eys, MD
Usual Residence of												
10a. State	10b. County		10c. City	y, Town or Lo	cation						1	0d. Inside City Limit
MD	Daval	oodtor	775	.enna								1 ☐ Yes 2 ☒ N
MD 10e. Street and Nu		nester		ema	10f. Zip Code				10a C	itizen of V	Vhat Cour	ntry?
						60			rog. c	USA	mat cour	my:
4887	Old Ro				218							
11. Marital Status		12. Was Dec Armed F	cedent Ever in U. Forces?	S. 13. V	Vas Decedent of H f Yes, specify Cuba	lispanic Ori an, Mexicar	igin? (Sp n, Puerto	ecify Yes or N Rican, etc.)	0-		e - Americ k, White,	ean Indian, etc.
1 Never Marr		If Yes, G	2 ⊠No ive	•	I ☐ Yes 2⊠ No	Specify:				Specify	. Bla	ck
3 → Widowed	4 Divorced	Year or								Opechy		
/S00		t's Education st grade completed	0	16a. Deced	lent's Usual Occup	ation	t of work	ina	16b.	Kind of Bu	isiness/Ind	dustry
Elementary/Seco			(1-4or 5+)	life. L	kind of work done of NOT use retired	d)	i or work	"Ig				
6th	oridary (0 12)	Comogo	(1 10, 0.7	F	Homemaker					omest	ic	
17. Father's Name	(First, Middle,	Last)				18. Mothe	er's Name	e (First, Middle	, Maide	n Sumam	e)	
George	_					M	larv	Ann Pin	nket	t		
		hin (Time Cried)		105 14-17	a Address /Ctra						Ctoto 7	Cado
19a. Informant's N					g Address (Street 28 Double							
Mr. Wilb	our But	TET\ 2011				CTEE						
20a. Method of Dis		• CB	1 ^	lace of Dispo- emetery, cren	sition (Name of natory or other plac	ce)	[	Date	20c.	Location -	City or To	own, State
1 kg Burial 2 ` 4 □ Donation		3 □Removal from Specify)	r State Fed	deral E	Hill Ceme	tery	May	20, 06	Fed	deral	sburg	g, MD
21. Signature of Fi						-,						
	1 77	7/2	11-		. Name and Addre Jolley Me	meria	1 0	arel-	Sa T i	3 56	rsey	21801
- de	rella	XJ. XP	cen								,	
23a. Part 1. In r	ne disease, or art failure. List	only on o use on	caused the death	n. Do not ente	er the mode of dyin	ng, such as	cardiac (	or respiratory a	arrest,			Approximate Interval Between
Immediate Cause	(Final	V (	onges	Live	Henry	L PM	1/21	71				Onset and Death
disease or condition resulting in death)	on	a. Due to	o (or as conseq		· Henri	1 "/						7/3
		Due to									)	
			· V ·	uence or).								
Sequentially list co	onditions,	b. — Dup to	V									
if any, leading to in	nmediate	b. — Due to	o (or as a consequ									
if any, leading to in cause. Enter Unde Cause (Disease or that initiated event:	nmediate erlying ' injury s	<b>S</b>	o (or as a consequ	uence of):								
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Registrar
DHMH 17 Rev 1/2001

State

		1 - For Amend Item 18 State Registrar  1. Decedent's Name (First, Middle, Las								2. Date of Death Month	Day	Year	3. Time of Death
hysici /Medic		WILLIAM EDWARD	BROOKS							MAY 25,	2006	1001	07:05 A
xamin		4a. Facility Name (If not institution, give		)				Location of			4c. Cou	nty of Death	1
		CHESTER RIVER MA		//		If Under		TERTO		0.5 / / 01 / 1	1	ENT	
neral ector		5. Social Security Number 6. S 220-12-6705	8X 7. A K M 2 □ F	ge (in yrs. i	ast birthday) O Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, 10/02/	Year) 1925	9. Birth	place (State or Forei intry) MD
in Eal	or	10a. State 10b. County MD KENT			OCK HA								10d. Inside City Lim
I Dis notif	Director	10e. Street and Number 21165 GREEN LAN	E			10f. Zip	Code 2166	1		10		of What Cou	intry?
other than natural, or tains 250 of 2004.  event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 X Yes 2 I If Yes, Give Year or Dates:	? No		Was Deced f Yes, spec 1 ☐ Yes 2		spanic Orig n, Mexican, Specify:	in? (Spe Puerto	acify Yes or No- Rican, etc.)	14. F	Race - Ameri Black, White cify: WHI	, etc.
the Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 1 2		5+)	life. L	lent's Usua kind of wor DO NOT us RAFTS.	rk done d se retired)	uring most	of worki	ing		Business/II	<b>,</b>
	To Be C	17. Father's Name (First, Middle, Last) ROBERT PATRICK BI	ROOKS				1	18 Mother 1 za M/12	s Name peth	(First, Middle, M. Dewa	aiden Sum DEWA	ame)	
r trau		19a. Informant's Name/Relationship (in JEANNE BROOKS/WI)								I/Route Number, CK HALL,			o Code)
rry or othe		20a. Method of Disposition 1 ☐ Burial 2 🌣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		CA	ace of Dispo emetery, cren ESAPEAI	natory or of	ther place	ORY 0.				in - City or T NSVILL	
any injury or		21. Signature of Funeral Service Licent	elfl-	5	F	ELLOW	S. H	s of Facility ELFENI	BEIN CHE	AND NEW	NAM I	FUNERA 21620	т. номе
ician dical		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each	ine. Mdv	Do not enter								Approximate Interval Between Onset and Death
niner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		you.	e G	عهزم	oma		_				3 week
na burial-transit	cai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as		ence of):						_		10 4.5.
by the attained by the state of	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetel	death 3	Ectopic pre						Date of deliv Month	ery Day Year
ba da	ρ	Part II. Other significant conditions of	ontributing to death I					n in Part I.		23e. Did toba	<b>\</b>		he cause of death?
ractor, paga 2 should	Completed	L'sase, anon	ic rend						_	24a. Was an autopsy perform		o. Were auto prior to co death? 1 \( \text{Yes}	opsy findings availab impletion of cause of
funaral d	tion: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death Natural 5 Pending investigation	Hospital: 1  Inpati 28a. Date of Inj (Month, Da	Jry	ER/Outpatien 28b. Time of Injury		A Other Bc. Injury Work	4 Nurs	sing Hon	ne 5 Resider	ce 6 □C		(y)
ed in by tha	Certification:	3 Suicide 6 Could not be determined	28e. Place of In	jury - At hor tc. (Specify	me, farm, stre	et, factory,				28f. Location (Stre City or Town,		mber or Rura	al Route Number,
	Medical	29a. Certifier (Crieck only one)  Construity  Climate only one)	ysician: To the best árier. On the basis of and manner si	if examinati	vledge, death ion and/or inv	occurred a restigation,	at the time in my opi	e, date and nion, death	place, a occurre	and due to the cau ed at the time, dat	ise(s) and i	manner as s e, and due to	tated. o the cause(s)
plataly filled	2	29b. Signature and title of certifier					License	_	_	29	d. Date sign	ned (Month,	Day, Year)
complataly		MA		MD			<b>D</b> P	173	5		5/2	5) P	<b>c</b>

Physician /Medical Examiner Examiner that the death certificate be executed

Physician

/Medical

Examiner

10a. State

Director

ð

MD

**Funeral** 

Director

•how

r than "naturel", or items 23a or 28a-f ehov the Mudical Esa atter must be notified at

72 hours after

marked other than

Health and Mental

Maryland 21215-0036

Baltimore,

Box 68760

P.O. I

Division of Vital Records,

or Attending

use as the burial-transit attending physician ed by the a s been signed by the should be detach. funeral After death. To the Funeral Director: after within 24 hours a To the Funeral L

Physician/Medical

2

Be

Certification: To

Medical

HEMIPARESIS

25. Was case referred to medical examiner? 1 Yes 25 No 27. Manner of Death

1 Natural

2 Accident

5 Pending

6 Could not be

2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

VV

29c. License number D0041587 29d. Date signed (Month, Day, Year) 06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. Noble, M.D. 122 Speer Rd. Chestertown, MD

State Registrar 31. Date filed (Month, Day, Year) MAY 2 2 2006



		4	For State	State of M	aryland	/ Departme			nd Mental Hy	71	06	17804
	A 71	R L	Registrar  1. Decedent's Name (First, Middle	, Last)		Octano	ato or E	Jean	2. Date of De	Reg. No."		3. Time of Death
F 3	Physici		william m	Barla	. /				Month	Day 20	Year	1155 M
	/Medic Examir		4a. Facility Name (If not institution,	give street and number)	7	4b. Ci	ty, Town, or	Location of	Death		inty of Death	[,,,,,
*		462°	chester Riv	er Hospil	tal Ce	nter c	hes	four	) .	K	ent	
Ģ.	Funeral			6. Sex 7. Ag	e (In yrs. lasi	Month	der 1 Year	If Under 24 Hours	Min. 8. Date of Bi	rth ay, Year)	9. Birthp Coun	lace (State or Foreign
	Director		449-50-9245	IMM SUP	68	Yrs.			NOVEMBE	ER19,19	37	NM
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	Town or Location					1	0d. Inside City Limits
	Mary -f sh	호	MD KEN	${f T}$	CH	ESTERTOW	N					1 Yes 2 □ No
	r 28a	Director	10e. Street and Number		.1	10f.	Zip Code			10g. Citizen	of What Coun	ntry?
	th with	a D	116 WASHINGTO	N AVE.			2162	20		U	SA	
Maryland 21215-0036	hours after death with the Maryland tural', or Items 23a or 28a-f show al Examener must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 🛣 Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? ed 1 Yes 2 X If Yes, Give Year or Dates:			cedent of Hi pecify Cubar 2 No	spanic Origin, Mexican, I	n? (Specify Yes or No Puerto Rican, etc.)		Race - Americ Black, White, acify: WHI	etc.
5-0	72 In an	etec	15. Decedent' (Specify only highes		1	16a. Decedent's U (Give kind of	work done a	lurina most o	if working	16b. Kind o	f Business/Ind	dustry
21	d within piene. r than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	PROFESS	Γuse retired,	)	, and the second	FDUC	ATION	
7	filed v Hygie other t		17. Father's Name (First, Middle, L			11101 201	7010	18 Mother's	s Name (First, Middle			
and	ba is p	9 Be	WILLIAM LEONARD	,					L SHOWALTE		ame)	
Z	d 2 should th and Men 7 is marke traumatic	은	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailing Addre	ess (Street a	ind Number	or Rural Route Numb	er, City or To	wn, State, Zip	Code)
Š	d 2 Ith a 27 Is		MARGO BAILEY/W	IFE					., CHESTER			
ē,	ges 1 and t of Healt if item 2 or other		20a. Method of Disposition		20b. Plac	e of Disposition (f	Vame of	a)	Date	20c. Location	on - City or To	wn, State
Ē	Pages nent of I ant: If it ury or o		1 ☐ Burial 2 【ACremation 4 ☐ Donation 5 ☐ Other (Sp		CHESA	APÉAKE ĆI	REMATI	ON O	5/21/2006	STEVEN	SVILLE	, MD
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service L	icensee Helfenl	sein	FELLO 130	and Addres DWS, H SPEER	ELFENI ROAD,	BEIN AND N CHESTERTO	EWNAM WN, MD	FUNERA 21620	L HOME, P.A
185,4			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caused only one cause on each li	d the death. I	Do not enter the m	ode of dying	g, such as ca	rdiac or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	- GAST	ROIN	TEST 1/	VAL	B	LEEDI	NG	4	Onset and Death
1	/Medical Examiner		resulting in death)									70 1 1 1
	78	_	Sequentially list conditions,	b. NoN Due to (or as		KINS	Liv	NPH	omA			sevent year
	nsit	nin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<b>S</b> 10 (0 0								
Ć,	be executed sicien and burial-transit	Examine	that initiated events resulting in death) Last	C. Due to (or as	a consequen							
8760,	cate be ex physicien the burial	all				ice of):						
9	fical ph)	0		d		nce of):						
×	⇒ S <sub>1</sub> α	dedical		d		ice of):						
.O. Box	the death certific by the attending p ached for use as f	nysician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	of pregnancy	y path 3⊟Ectopic					Date of delive Month	ry Day Year
P.O.	is that the death certi gned by the attending ie detached for use a	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  Part II. Dther significant condition	d	of pregnancy 2	y path 3□Ectopic h 5□Other	(specify)	n in Part I.	23e. Did		Month	•
P.O.	equires that the death certi en signed by the attending ould be detached for use a	by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  Part II. Dther significant condition	d	of pregnancy 2	y path 3□Ectopic h 5□Other	(specify)	n in Part I.	23e. Did 1	tobacco use c	Month	Day Year
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			for State Registrar	State of M	arylan		artment of F			ental H	ygiene Reg. No	ZIIIIh	17805	)
		ri.	1. Decedent's Name (First, Middle	, Last)						2. Date of E	eath Da	y Year	3. Time of Death	
	Physici /Medic		Suk Cha	Choe						May 1		006	12:00 p <sup>M</sup>	
	Examin		4a. Facility Name (If not institution,	give street and number,			4b. City, Town, o	or Location of	of Death	-	4c	. County of Dea	th	
, Š			Montgomery Gene	ral Hospita	1		01ney_				l l	Montgome		
	Funeral					last birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs.	8. Date of E (Month, L	irth Day, Year)	9. Bir	thplace (State or Foreign ountry)	ŀ
8	Director		227-21-9886	1□ M 2□ F	77	Yrs.			J	uly 14	192	28 Kor	rea	
	pu k		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	ecation						10d. Inside City Limits	_
	aryla •ho	ž				•							1 ☐ Yes 2 No	
	Ne N	Directo	Virginia Fairfa	X	Ann	andale	10f. Zip Code				10g Cit	tizen of What Co	ountry?	_
	with	ā		"									*	
	23.	era	6925 Columbia P	ike, #228	Ever in 11	C 13 1	22003		igin? (Spec	rfy Yes or N	- 11	ted Stat		_
	them frent	in in	11. Marital Status 1 □ Never Married 2 □ Marri	Armed Forces	No.	.3.	Was Decedent of h If Yes, specify Cub	an, Mexicar	n, Puerto R	lican, etc.)		Black, Whit		
36	rs af	by F	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🕅 No	Specify:				Specify: As	sian	
Ş	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or Iteme 23a or 28e-f ehow sht, the Medical Executar must be notified at	Completed by Funeral	15. Decedent	's Education		16a. Dece	dent's Usual Occup	pation			16b. K	(ind of Business	/Industry	
7	n n	pie	(Specify only highes Elementary/Secondary (0-12)	t grade completed)  College (1-4or	54)	(Give	kind of work done DO NOT use retire	during mos id)	st of workin	g				
7	r tha	E	12	College (1-40)	3+)	House	wife				Own	n Home		
Baltimore, Maryland 21215-0036	otho ont,	BeC	17. Father's Name (First, Middle, I	Last)				18. Mothe	er's Name	(First, Midd	le, Maider	n Sumame)		
a	lid be	ToB	(Unavailable)					(Unav	ailab	1e)				
ary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28e-f ehow amounts: If item 27 is marked other than "natural", or iteme 23a or 28e-f ehow and injury or other traumatic event, the Modical Experiment must be notified at once.	Ī.,	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	ng Address (Street	and Numb	er or Rural	Route Num	ber, City	or Town, State,	Zip Code)	
Σ	alth a		Kwan Sun Choe /	Son		7412	Seabrook	La.,	Sprin	gfiel	d, Vi	irginia	22153	
ē,	t tem		20a. Method of Disposition	- 30-	1 -	Place of Dispo	sition (Name of matory or other pla	ce)	Da	ite	20c. L	ocation - City or	Town, State	
Ē	Page in the second		1 ABurial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		1	-	Memorial		5/23/	2006	Fair	rfax, Vi	irginia	
==	oorta		21. Signature of Funeral Service	icensee		22	Name and Addre	ass of Facili	tv					
m	Depar Impor any ir	1	1 / Th	ll_	M0095	56	Fairfax M 9902 Brad	lemori Idock	Road.	neraı Fair	fax.	e Virgini	ia 22032	
	6.		23a. Part1. Enter the disease, or	complications that cause	d the deat								Approximate Interval Between	
	Physician		shock, or heart failure. List of Immediate Cause (Final			struck	Heart	- C	· O.	0			Onset and Death	
18	/Medical		disease or condition resulting in death)	a. Due to (or a:	s a consec	uence of):	hic H	10					17'	_
	Examiner			all all	200	Sclere	he H	conf	- Dr.	seas	(		7/7/	
51.4		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as						-				
	uted d ansit	Examiner	Cause (Disease or injury that initiated events											
á	exec an an rial-tr		resulting in death) Last	Oue to (or as	s a conseq	uence of):								_
8760,	death certificate be executed e attending physician and id for use as the burial-transit	icai		d										_
9	tifica ng ph as th		IF FEMALE											
Вох	eath certifi attending   for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			∃Ectopic pregnanc	v				23d. Date of de	•	
	deat	Sicie	in the past 12 months?  1  Yes 2 No	4□Pregnant a			Other (specify)	,				Month	Day Year	
P.0	that the de led by the a detached t	hys	9 ☐ Unknown ( \	9E OHKHOWIT										
	res tha igned be det	by F	Part II. Other significant condition	ins contributing to death	but not res	ulting in the u	nderlying cause gr	ven in Part I	l.	23e. Dio	tobacco		the cause of death?	
pro	w require been sign		>eps(s							1	Yes 2	.□No 3□Pi	robably 4 Unknown	
Records,	e law requires has been sign je 2 should be	pie								24a. Wt	is an	24b. Were at	utopsy findings available completion of cause of	
m	0 - 0	Completed								per 1 Yes	formed?	death?	1	
Vital	ician: Th certificate rector, pag	0	25. Was case referred to medical					26. Place	e of Death	(Check only			7	
>	y S	To B	examiner? 1  Yes 2	Hospital: 1 XI pat	ient 2	ER/Outpatier	nt 3 DOA	her: 4 □ Ni	ursing Hom	e 5□Re	sidence	6 ☐Other (Spe	icify)	
ס ר	ding Ph h. After th funeral	1	27. Manner of D-ath	28a. D te of Inj (Month, D	ury av Year)	28b. Time o Injury	f 28c. Inju Wo	ry at	2	8d. Describ	e how inju	iry occurred		
<u>ō</u>	Attending r death. ector: After oy the fune	atic	1 Natural 5 Pending	gation		,,		Yes 2	No					
Division	r Atte	tific	3 Suicide 6 Could r	ined 289. Place of it	njury - At h	ome, farm, sti	reet, factory, office		2		(Street ar		ural Route Number,	1
	talol rs aft al Di	Certification:			( - ,							,		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral or the funeral o	edicai	29a. Certifier 1 Certifyin	g Physician: To the bes Exeminer: On the basis	t of my kno	owledge, deat	h occurred at the ti	me, date ar	nd place, a	nd due to th	e cause(s	and manner as	s stated.	
	he H in 24 he F plete	edi	one)	and manner s	tated.		vostigation, army	opinion, doc			5, 0216 011	u piace, and due		
		Σ	29b. Signature and title of certifier	7			29c. Licen	se number			29d. Da	ate signed (Mont	th, Day, Year)	
•	3		100	-/(01)			Dos	25	45		NO	y 1.7,	, 2000	
			30. Name and address of person	who completed cause of	death (Iter	m 23a) (Type,	Print) GOD	iw the	- 0	0007	1 ou	1	1 -	
_			30. Name and address of person 75 (3 New 31. Date filed (Month, Day, Year)	Mupshi	<b>*</b> C	Hen	ue, To	a Cen	at	arle	M	० २०७१	2	
La g		ate	31. Date filed (Month, Day, Year)	2006 32 Regis	trar's Signa	ature	andi)							
8/3	Regist	rar	MIAI 6 6	2000	41	- 19								

State of Maryland / Department of Health and Mental Hygiene

						Ce	rtificate	of Deat	h		Reg. I	No.	UO	1/0	UU
	6	1. Decedent's Name	(First, Middle, La.	st)						2. Dete of I		Day	Year	3. Time of D	eath
	Physician	Edward Fra	ancis Chaml	œrs						_		2006	Tea!	6:42 a	.m.
	/Medical Examiner	4e Fecility Name (If I	not institution, giv	e street and nu	m <i>ber)</i>			4b. City,	Town, or Lo	cation of De	ath	4c. County	of Deeth		
	LXammer	Holy Cross	Hospital					Si	lver Sp	ring		N	1ontgor	nerv	
	Funeral	5. Social Security Nu	_	ex	7. Age (In yrs	. last birthday	If Under 1 Y		er 24 Hrs.	8. Date of I	Birth			ace (State or I	Forei <b>g</b> n
	Director	204-20-9803	1	13 M 2 □ F	78	Yrs.	Months D	ays Hours	s Min.	(Month, )				ny) Isylvania	
		Usual Residence of D					1								
	ylan	10a. Stete	10b. County		10c. C	ity, Town or L	ocation						10	d. Inside City	
	Mar Med all	Maryland	Montgome	erv	Si	lver Spr	ina							1 ☐ Yes 2	No ∏
	h the	10e. Street and Numi	ber				10f. Zip Co	de			10g.	Citizen of W	hat Count	try?	
	h wit	812 Malt	a Lane				2090	1			ŀ		USA		
	ifer death with the Ma r Items 23a or 28a-f s niner must be notified Funeral Director	11. Meritel Status		12. Was Dec	edent Ever in I	J,S. 13.	Was Decedent	of Hispenic (	Origin? (Spe	cify Yes or I	No-		e - America k, White, e		
>	P. Fu	1 Never Marrie	d 25 Married	tx⊡ Yes	2 No		1 ☐ Yes 2 ₩			rtioari, otc.,				nc.	
2	filed within 72 hours after death with the Maryland Hygiena. ther than "natural", or flams 23a or 28a-f show but, the Medical Examiner must be notified at a Completed by Funeral Director	3 ☐ Widowed 4	□Divorced	If Yes, Gi Year or D	ve Dates: 1946	-48	ILITES ZOX	NO Speci	ry.			<i>Specity.</i>	White		
712-0020	be filed within 72 hou tal Hygiena. I other than "nature twent, the Medical Event, the Me	(Specific	15. Decedent's Ed	lucation		16a. Dece	dent's Usual O	ccupation	ost of worki	na	16b.	Kind of Bu	siness/Ind	ustry	
7	a. Bu	Elementary/Second		College (		life.	DO NOT use re	etired)							
7	on Con			2		Budg	get Analy	st			Fee	deral G	overm	nent	
yland	al Hygin I other went, the	17. Father's Name (F	irst, Middle, Last)					18. Mo	ther's Name	(First, Midd	lle, Maid	len Sumam	e)		
<u>a</u>	should be ind Mental I in marked of urmatic eve	Edward Cha	mbers					Hele	en Hyer						
Маг	2 shou and M la mar la mar saumat	19a. informant's Nan	ne/Relationship (	Type, Print)		19b. Mail	ing Address (St	reet and Num	ber or Rura	i Route Num	nber, Cit	y or Town,	State, Zip	Code)	
	s 1 and 2 should be file. I Haalth and Mental Hyg. tem 27 is marked othe other traumatic event,	Suzanne D. C	hambers/V	Vife			lta Lane		: Sprin	g, Mary	land	20901			
ore,	of He	20a. Method of Dispo	sition Cremetion 3 [	Domousi from	20b.	Place of Disp cemetery, cre	osition (Name of matory or other	f place)	M	Date ay 22,	20c.	Location -	City or Tov	vn, State	
Ĕ	Peges nent of l int: If Its Iry or o		Other (Specif		Gat	e of Hea	ven Cem	etery		2006	Silv	ver Spr	ing, I	⁄arylanā	
baltimor	permit. Peges Department of Important: If It any injury or o	21. Signature of Fund	eral Service Li	60		2	2. Name and A rancis J	ddress of Fac	cility	ral Hom	n Tne	,			
٥	P P E E G	1	h_ E.1	jour	)	1	OU Unive	rsity Bl	Lvd, W,	Silver	Spr	ing, ML	2090]		
	-	23a. Part1. Enter the	disease, or com	plications that	aused the dea	ith. Do not en	ter the mode of	dying, such a	as cardiac c	r respiratory	errest,		-	Approximate	
	Physician	shock, or heart	fallure. List only	one cause on e	each line.								1	Interval Betwee Onset and De	ath
	/Medical	Immediate Cause (F	inal												
	Examiner	disease or condition resulting in death)		a. Myocar	dial Inf	oras a conse	anaboa off:					-	30	) Minute:	S
٠,	ě e				Due 10 1	O 23 4 CO 130	querios oi).						1		
	eath certificate be executed ettending physician end ifor use as the buriel-trensit clan/Medical Examiner	Sequentially list con-	ditions	b	Due to (	or as a conse	guence of):						- 1		
'n	sertificate be executed ding physician end se as the buriel-trensit	Sequentially list conditions, leading to immoduse. Enter Underly Cause (Disease or in	nediate ving				,						Ì		
00/00	ficate be physicials to the bu	that initiated events		C	Due to (	or es a conse	quence of):						-		
	g phy as th	resulting in deeth) La	ist		,								j		
200	anding use a			d									1		
	death	Part II. Other signific	ant conditions of	ontributing to d	eath but not re	sulting in the u	inderlying caus	given in Pa	rt I.	23b. Di	d tobac	co use con	tribute to	the cause of	death?
j.	v raquiras that tha death or been signed by the etten should be detached for un leted by Physician						, ,			1[	Yes	2⊠ No	3 Prob	ably 4 ☐ Ur	nknown
,	as tha igned be de	Prostate Ca	incer												
ras,	raquiras that tha										es an au			re autopsy fine	dings
3	law rains bee		-							ре	nomied		con	pletion of cau eath?	ISB
ב	Tha taw raquir sate has been s paga 2 should									*1	Yes	2 X No	1	Yes 2□N	io
O	or, pa	25. Was case referre	d to medical					26 Pla	ce of Death	(Check ont		2 02 110	,		
5	Physician: r this certific ral director, r. To Be	examiner? 1 ☐ Yes 2 ☑ N		Hospital:	Inpatient 2√2	ER/Outpatie	nt 3 DOA	Othor:		ne 5□Re		6 □Othe	r (Specify	)	
5	Phy rrthis aral o	27. Manner of Death			of Injury th, Day Year)	28b. Time o		Injury et Work?		28d. Describ				/	
5	ding th. Afte tfunction	1 ⊠Natural 2 □ Accident	5 Pending investigation		th, Day Year)	Injury	М	Work? 1∐Yes 2i	□No						
VISION	Attending Physician: The law of death.  ector: After this certificate has by the funeral director, page 2 biffication: To Be Comp	3 Suicide	6 Could not be determined	286. Place	of Injury - At I	ome, farm, st	reet, factory, of	ice	- 2				er or Rural	Route Numbe	9 <i>r</i> ,
5	tal or Attending P rs after death. al Director: After t led in by tha funer? Certification:	4 🗌 Homicide	401011111100	build	ing, etc. (Spec	ify)				City or T	own, St	ate)			
			☑ Certifying Ph												
	he Hospi in 24 hou he Funer pletely fil		☐ Medical Exam	niner: On the b											
	Nethin Somp	29b. Signature and ti	tle of certifier				29c. Lie	ense numbe	r		29d. [	Date signed	(Month, E	Day, Year)	
	12 1	▶ LV	ML	12	MD		D2:	9675				Ma	y 19,	2006	
	12+1	30. Neme and addres	s of person who	completed caus	e of death (Ite	m 23e) (Tvpa	Print)				l				
		Ralph Bocci				,	hesda, M	aryland	20817						
9	State	31. Date filed (Month		38. F	tegistrar's Sign	ature /	ake B							111 1211 12	
	Registrar	WA	Y 2 2 20	05	legistrar's Sign	The party of	Section 1								

			For State Registrar	State of M	laryland / De	partmen ertificat			nd M		giene <sub>2</sub>	006	178	307
	Physic		1. Decedent's Name (First, Middle Ernest	, Last) Aubre	v	Co1	lisc	on		2. Date of Dea Month May		2006	3. Time of 5:30	
	/Medi Examir		4a. Facility Name (If not institution 1620 Chesape	, give street and number			Town, or	Location of		1149	4c. Cour	nty of Death		Р
	Funeral Director		5. Social Security Number 219-12-3515		ge <i>(In yr</i> s. <i>Iast birthd.</i> 85 Yrs	ay) If Under Months		If Under 2	4 Hrs. Min.	8. Date of Birtl (Month, Day Oct. 12	Year) 1920	9. Birthp Cour Mary	place (State on ntry) 1and	r Foreign
	Maryland t-f show fied at	tor	Usual Residence of Decedent  10a. State 10b. County  MD Anne	Arunde1	10c. City, Town or							1	0d. Inside Cit	,
	with the	i Direc	10e. Street and Number 1620 Chesapeak	e Lane		10f. Zip		.106			10g. Citizen d		ntry?	
336	be filed within 72 hours after death with the Maryland tel Hyglene. d other than "natural", or Items 23s or 28s-f ehow event, the Medical Explaint rival be notified at	by Funeral Director	11. Marital Status  1 Never Married XXMarri 3 Widowed 4 Divorced	12. Was Decedent Armed Forces'	? No	3. Was Deced If Yes, spec	lent of Hi		in? (Spe Puerto F	cify Yes or No- Rican, etc.)	14. R	ace - Americ lack, White,		
Maryland 21215-0036	within 72 hou lene. than "natura the Medical E	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12	's Education	16a. De (G. iife	cedent's Usua ive kind of wor a. DO NOT us	rk done d se retired	luring most (		g .	16b. Kind of		dustry e1 Cou	ntv
yland 2	be filed tel Hygi d other	To Be Co	17. Father's Name (First, Middle, Ernest E. Coll	ison				18. Mother	's Name y Sm		Maiden Sum	ame)		псу
	1 and 2 Health a em 27 is ther tra	0.	19a. Informant's Name/Relationsh Martha Lee Col 20a. Method of Disposition			20 Ches	apea	ke Laı	ne,	Route Number Mayo, Mayo		16		
Baitimore,	permit. Pages Department of Important: If it eny injury or o		1 XBurial 2 Cremation 4 Donation 5 Other (St  21. Signature of Funeral Serve I	necify)	Mayo U.	M. Cem	eter	y 5-		2006 Home, F	Mayo,			
	\$0 E \$ 8		23a Part1 Enter the c seas or shock, or heart fillure. List of	complications that cause only one cause on each l	d the death. Do not e	905	<u> сате</u>	SATTT	<u>е ко</u>	ad, Gal	.esvill	e, MD	20765 Approximate Interval Betw	veen
	Physician /Medical Examiner	Examiner	Immediate Cause (Fir al discusser recondition results of in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence of):  a consequence of):  a consequence of):	d nei	ck	Com	cer	/			Onset and D	my)
O. BOX 68/60,	w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d. 23c. If yes, outcome	of pregnancy	3∏Ectopic pre 5∏ Other (spe						ate of delive	_	ear .
ras, P	law requires that the as been signed by th 2 should be detache	٦	Part II. Other significant condition	contributing to death be	out not resulting in the	underlying ca	iuse give	n in Part I.		23e. Did tol			e cause of de	
	The la ate has page 2	Completed	('OP!	) / As'	Mm A.				_	24a. Was a autops perform	y	prior to con death?	osy findings a npletion of car 2 No	vailable use of
sion of Vital	syd Sidiji	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending investig.	ation	ry 28b. Time		Bc. Injury Work	r: 4 🗌 Nursi	ing Hom	Check only on e 5 Reside 3d. Describe ho	nce 6 🗆 Ot		)	
DIVISION	To the Hospital or Attending Pl within 24 hours atter death. To the Funeral Director: After th completely filled in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	ned 286. Place of Inj building, et	ury · At home, farm, c. (Specify)					3f. Location (St. City or Town	, State)			e <i>r</i> ,
	thin 24 hours thin 24 hours the Fune mpletely fi	Medical	29a. Certifier (Check only one)  1 Certifying 2 Medical E	Physician: To the best xaminer: On the basis o and manner st	t examination and/or	investigation,	in my opi	inion, death	place, ar occurred	d at the time, da	ate and place	, and due to	the cause(s)	
	T W T	-	30. Name and address of person w	mo completed cause of o	leath (Item 23a) (Tun		License	214		3	Moy	19	200	6
	Sta	te	MILHAD J. 31. Date filed (Month, Day, Year)	a Registr	ar's Signature	445		EFEN	SE	464	WAY	AN	NAPULI 2	MI)
	Registr	ar	MAY 19	2006	S S	ade							•	1

			1 - State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of F			Reg. No.	6   7808
	Physicia	an	1. Decedent's Name (First, Middle, Last) Shirley VanSant	Carson				2. Date of De. Month	Day Y	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give st			4b. City. Town. o	Location of Dea	May	16 200 4c. County of	
	Examin	ier	Regency Park Assis		g		Gambrill			e Arundel
31	Funeral Director		5. Social Security Number 6. Sex 10	7. Age	(In yrs. last birthday 70 Yrs.	) If Under 1 Year Months Days	If Under 24 Hrs Hours Min		v, Year)	Birthplace (State or Foreign Country) ennsylvania
<u> </u>	> -		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or L	conting				10d, Inside City Limits
Aaryla	r shove	ō	Maryland Anne Aru		TOO. City, TOWN OF E		brills			1 Tyes 2000No
the	288-	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Who	at Country?
th wit	23a o		2313 Nancarles Dri	ve			21054		U.S.	.A.
ar dea	tems ser.ms	Funerai		2. Was Decedent E Armed Forces?		Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14. Race - Black,	American Indian, White, etc.
is affe	I', or I	by F	1 ☐ Never Married 🏂 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2€2€No ft Yes, Give Year or Dates:		1 ☐ Yes 💥 No	Specify:		Specify:	White
2 Po	natura Ical E	ted	15. Decedent's Education (Specify only highest grade	ation	16a. Dece	edent's Usual Occup	ation	urkina	16b. Kind of Busin	ness/Industry
ithin it	han ".	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	life.	DO NOT use retired Homemak	1)	9	Or wo III	
y beli	Hygier ther ti nt, in		17. Father's Name (First, Middle, Last)	4		Hollellak		me (First, Middle	Own Ho	Ditte
should be filed within 72 hours after death with the Maryland	to Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Mcdical Examiner must be mutilled at	To Be	John Arthur VanSa		1		Thelma	Deery	·	
Walan d 2 st	th and 7 Is n traun		19a. Informant's Name/Relationship (Type Scott Carson/son	e, Print)		ing Address (Street Nancarles			-	
S 1 and	f Healitem 2		20a. Method of Disposition		20b. Place of Disp			Date	20c. Location - Ci	
Pages 5	nent o unt: if ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Rose Hill	Cemetery	5/23			ington, PA
permit	Department of Health ar Important: if item 27 Is any injury or other trau once.		21. Signature of Edheral Service Licensee	Lit						meral Home Lis, MD 21401
- Pl	hysician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused to cause on each line	€.	nter the mode of dyin			rrest,	Approximate Interval Between Onset and Death
	Medical xaminer		resulting in death)	Due to (or as a	consequence of):		7.3.51.10			7
\$ 18		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):		-			
ate be executed	ohysician and the burial-transit	i Examiner	that initiated events c. resulting in death) Last	Due to (or as a	consequence of):					
cateb	physic s the b	dica	d.							
The law requires that the death certific	been signed by the attending p should be detached for use as	hysician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	,
that th	ed by detac	Q.	Part II. Other significant conditions cont	ributing to death but	not resulting in the	underlying cause giv	en in Part I.	23e. Did to	obacco use contribu	ute to the cause of death?
requires	een sign	eted by						101	res 2 0 31	☐ Probably 4 ☐Unknown
The law		Completed						24a. Was autop perfo 1  Yes	osy prio rmed? dea	Yes 2□ No
Siciar	certif	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	spitaf:	t 2 ER/Outpatie	ort 3 Doa Oth		ath Check only o		ted Living (Specify) Facility
ing P. V.	After this uneral d	<del> </del>	27. Manner of Death	28a. Date of fnjury (Month, Day		of 28c. Injur Wor	y at k?		now injury occurred	<del></del>
r Attend	ter death irector: , n by the f	Certification:	2 Accident investigation 3 □ Suicide 6 □ Could not be 4 □ Homicide determined	28e. Place of Injur	y - At home, farm, s (Specify)		Yes 2□No	28f. Location (S City or Tov		or Rural Route Number,
To the Hospital or Attending Physician:	within 24 hours after death.  To the Funaral Director: After this certific completely filled in by the funeral director.	edical Ce	29a. Certifier Check only one! 2 Medical Examina	er: On the basis of e	examination and/or in	th occurred at the tirnvestigation, in my o	ne, date and place pinion, death occ	e, and due to the urred at the time,	cause(s) and mann date and place, and	er as stated. If due to the cause(s)
othe	o the omple	Med	29b. Signature and tiple of certifier	and manner state	<del>о</del> ц.	29c. Licens	e number		29d. Date signed (/	Month, Day, Year)
<b> </b>	· s = 0		> 16 Sixt	K Eden	mo	D 30	701		5/17/0	6
			30. Name and address of person who com	apleted cause of dec	ath (Item 23a) (Type	Print)	obert S. I	iden Vistina	1 714	01
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 19 200		's Signature		4 11 M	711 11/1	1	

	1	For State Registrar		Maryland / Dep <i>Ce</i>	artment of H			Reg. No.	6 17809
Physicia		Decedent's Name (First, Middle, La					2. Date of Dea Month	Day	3. Time of Death
/Medica	al -	FERDINAND RAMOS			4b. City, Town, or	r Location of D	MAY	16 20 4c. County of	
Examine	r	4a. Facility Name (If not institution, given ANNE ARUNDEL MED)			ANNAPOL		ega ii i	1	ARUNDEL
- Funeral		5. Social Security Number 6. S		Age (In yrs. last birthday,	If Under 1 Year	If Under 24			9. Birthplace (State or Foreign Country)
Director		215-06-0281	1 <b>X</b> M 2□F	55 Yrs.	Months Days	Hours N	Min. (Month, Da APRIL	11,1951	PHILLIPINES
p >	<b>⊢</b>	Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or L	ocation				10d. Inside City Limits
anyla shov	. 1	200							1 Tyes 2 No
the N	Director	MD ANNE A	KUNDEL	ANNAPOL	10f. Zip Code			10g. Citizen of Wh	nat Country?
With with	<u> </u>	120 CONLEY DRIV	r.		214	กร		USA	,
death ms 2;	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.S. 13.	Was Decedent of H	ispanic Origin	? (Specify Yes or No	14. Race	- American Indian,
U36  ours after death with the Marylan al, or Itams 23a or 28a-f show Examinar must be inclifted at		1 Never Married 2 Married	Armed Force 1 Tes 2 If Yes, Give	i <b>X</b> No	If Yes, specify Cuba 1 ☐ Yes 2 X No	sn, mexican, P Specify:	ueno Alcan, etc.)		White, etc.
215-0036 thin 72 hours after death with the Maryland e. an "natural", or Itams 23a or 28a-f show i Medical Examinar must be notified at	٥	3 XWidowed 4 ☐ Divorced	Year or Date					Specify:	FILIPINO
D-C	Completed	15. Decedent's E (Specify only highest gr		(Give	edent's Usual Occup s kind of work done o DO NOT use retired	during most of	working	16b. Kind of Bus	•
within ene.	d E	Elementary/Secondary (0-12)	College (1-4)	or 5+)	DO 1101 238 181116	′/		FOOD SEI	GOVERNMENT
ified wi		17. Father's Name (First, Middle, Last		Jook		18. Mother's	Name (First, Middle,		
	lo Be	ALEJANDRO TUGAB	CABAUATA	N		CEFF	ERINA RAMO	S	
laryla 2 should and Men is marke aumatic	I)	19a. Informant's Name/Relationship (	Type, Print)	19b. Mail	ing Address (Street	and Number o	r Rural Route Numbe	r, City or Town, S	tate, Zip Code)
ore, M	3/-	JUANA LEE/COUSI	<u>N</u>			DR., A	NNAPOLIS,		
00		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 €	Removal from Sta	20b. Place of Disp cemetery, cre	osition (Name of ematory or other plac	(8)	Date	20c. Location - C	ity or Town, State
tim ment tant: jury o		4 Donation 5 Other (Speci	(v)	BESTGATE			/20/2006	ANNAPOL	IS, MD
Baltimo permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service Lice	nsee		E. Name and Address FELLOWS, I CARE, P.A	HELFENE	BEIN & NEW	NAM CREMA	ATION & FUNERAL
Medical  State of executed the principle of the principle	al Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	as a consequence of):  as a consequence of):  as a consequence of):					
Hecords, P.O. Box 68/60, The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnan 9□ Unknow	n 2 🗍 Fetal death 3( It at time of death 5( In	□Ectopic pregnancy □ Other (specify) _		00-10-4	23d. Date Mont	h Day Year
COTCS, w requires th been signed should be d	۵	Part II. Other significant conditions Myocowolia	1 3	•	underlying cause giv	en in Parti.			tute to the cause of death?
of Vital Records, Physician: The law requires to this certificate has been signeral director, page 2 should be to the control of the control	Completed						24a. Was autop perfo 1 ☐ Yes	sy pri rmed? de	ere autopsy findings available or to completion of cause of ath?  Yes 2 \( \text{\text{\text{NO}}} \) No
ian: striffica etor, p	Bec	25. Was case referred to medical examiner?				26. Place of	Death Check only o		
Of VITA Physician: rthis certific	ု	1 ☐ Yes 2 📉 No	Hospital: 1 XInp			4 LINUISII	ng Home 5 Resid	lence 6 Other	(Specify)
<b>⊏</b> 2 2 2 2 2 2 1	::   	27. Manner of Death  1 X Natural 5 ☐ Pending	28a. Date of I (Month,	Injury 28b. Time of Day Year) Injury	Wor		28d. Describe h	low injury occurred	1
VISION Attending If death. ector: After by the funer	cat	2 Accident investigation 3 Suicide 6 Could not to				Yes 2 □ No			
DIVISION I or Attending after death. Director: After	Certification:	4 Homicide determined	288. Place 01	Injury - At home, farm, si , etc. (Specify)	reet, ractory, office		28f. Location (S City or Tox		or Rural Route Number,
	edical Ce	(Check only 2 Medical Exa	miner: On the basi	est of my knowledge, dea is of examination and/or in	th occurred at the tin	ne, date and p pinion, death o	lace, and due to the occurred at the time,	cause(s) and mani date and place, an	ner as stated. Id due to the cause(s)
To the within 2 To the complei	Med	29b. Signature and title of Certifier	I Re. /s	110	29c. Licens	e number	2	29d. Date signed	(Month, Day, Year)
1	1	30. Name and address of person who state filed (Month Pay Year) 8	completed cause	of death (Item 23a) (Type	Print)	C		> (1	)   4 0
		Sterd Bech	ر ولای	loor medical	LVOITHWA	y Uno	rapolos, t	vo —	
Stat Registra	e ir	31. Date filed (Month Day Year) 8	200 32. Re	strar's Signature	branks)				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician 12 2006 Lois Willing Creighton May 3:50 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3756 Sunnyside Road Dorchester East New Market If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
NOV. 16,1906 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕅 F 99 Nov. Maryland Director 216**-**56**-**1673 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at 1 Tes 2 No Maryland Dorchester Directo East New Market 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3756 Sunnyside Road 21631 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No ff Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Teacher Elementary School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental H Is marked otl Be Frank Alexander Willing Susan Emily Dunn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ges 1 end 2 s it of Health an Suzanne C. Trice/Daughter 4440 Blinkhorn Road, Hurlock, MD 21643 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Itel any Injury or ott 1 XBurial 2. Cremation 3 Removal from State 5 Other (Specify) 5/17/2006 East New Market, MD 4 Donation East New Market Cem. 21. Signature of Funeral Servide Zeller Funeral Home, P.O. Box 207, 106 Main Street, East New Market, MD 21631 Paul. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** Stase 18ACS no /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 prootths?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 ☐ Yes 2 🕽 🐼 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Yo 24a. Was an has autopsy performed' certificate 1 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Desidence 6 ☐ Other (Specify) 1 Yes 2 76 Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3 DOA ieral Director: After th filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Air completely filled in by the fu 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Qay, Year) on who completed cause of death (Item 23a) (Type, Print) 10.0. 100 MD Bramble ST 31. Date filed (Month, Day) Year) 32. gistrar's Signature State 1 8 2006 Registrar

			1- State of Maryland / Departr		Hygiene	2006   78
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	/Medic Examin		17014 000	. City, Town, or Location of Death		. County of Death
			Ruxton Nursing Center	Denton		laroline.
	Funeral				of Birth oth, Day, Year)	7 - 1 1//
	Director		Usual Residence of Decedent	Jul	9 14, 19	121 Virginia
	yland how		10a. State 10b. County 10c. City, Town or Location	on		10d. Inside City Limits
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3	ns 23	erai	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	2 16 38 Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rican, e	or No-	14. Race - American Indian,
9	after or Iter	Fun	1 ☐ Never Married 2 ☐ Married	s, specify Cuban, Mexican, Puerto Rican, e Yes 2 <b>12</b> No <i>Specify:</i>	tc.)	Black, White, etc.
21215-0036	72 hours after death with the Maryland 'natural', or Items 23a or 23a-f show olgal Examiner must be notified at	d by	3 Mar Widowed 4 □ Divorced Year or Dates:	11111		Specify Black
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Mar	nd 2 sh lith and 27 Is n traum		19a. Informant's lame/Relationship ( <i>Type, Print</i> )  19b. Mailing A	ddress (Street and Number or Rural Route		11 5 21638
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OE .	Pages nent of I nnt: If its ury or o		1 Ø Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)	4	6 Gr	asonville, MD.
Baltimore,	permit. Pages Department of Importent: If if any injury or conce.			ame and Address of Facility	200	,
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			23a. Pa(t) Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.		itory arrest,	Approximate Interval Between Onset and Death
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00	s been si	ojete	Chronie Kenal insufficience	248	. Was an	24b. Were autopsy findings available prior to completion of cause of
I Re	hysicien: The law his certificate has t I director, page 2 s	Completed by	Diabetes mellitus		autopsy performed? Yes 2 No	death?
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	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier  (Check one)  One)  Chack one)  (Check one)  (Check one)  2   Medical Examiner: On the basis of examination and/or invest and manner stated.	curred at the time, date and place, and due igation, in my opinion, death occurred at the	to the cause(setime, date an	) and manner as stated. d place, and due to the cause(s)
	ro the within of the somple	Me	29b. Signature and Itle of certifier	29c. License number	29d. Da	ite signed (Month, Day, Year)
			Meelle mo	035284	5	117/06
			30. Name and address of person who completed cause of death (Item 23a) (Type, Prin AMD NBA ACCOM MD 219 S.	D35284  Washington 8	+ Ec	eston mo 21601
	Sta		31. Date filed (Month, Day, Year) 32 Registrar's Signature			
DI	Regist	_	MAY 1 8 2006			

Amend #4A per Phy. 5-30-06 A.A.Co.Health Dept. PM Please Type or Print in Black Indelible Ink 06-03473 State of Maryland / Department of Health and Mental Hygiene Stephanie Elizabeth Deuso 2006 17812 1. For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 22, 2006 1210 hrs Stephanie Elizabeth Deuso **Medical Examiner** c. County of Death 4b. City, Town, or Location of Death 4a Estito Name (if not institution, give street and number)
Home Water Way Apt 303 Glen Burnie Anne Arundel If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or 5 Social Security Number 6. Sex 7. Age (In yrs last birthday) **Funeral** Foreign Country) Days Months Hours Min 300-46-3170 Ohio Director Feb. 22, 1965 1 M 2 **X** F Yrs Usual Residence of Deceder 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Yes 2 X No MD Anne Arundel Glen Burnie 28a-f show 23a or 28a-f show notified at once. 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6500 Home Water Way Apt. 303 21060 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12 Was Decedent Ever in U.S. must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 X Never Married 2 Married Yes 2 X No White If Yes. Give Year Yes 2 x No specify: Specify Widowed Divorced is marked other than "natural", atic event, the Medical Examiner ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Medical Lab es 1 and 2 should be filed within of Health and Mental Hygiene 4 Billings 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Julia Roether Robert Deuso ant: If item 27 is marked or other traumatic event, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဂ Baltimore, MD 196 West Paddock Circle Arnold, MD 21012 Robert Deuso/Father 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State crematory or other place) May 31, 1 X Burial 2 Cremation 3 Removal from State Pages 1 2006 Lakemont Mem. Gardens Donation 5 Other Specify Davidsonville,MD 22. Name and Address of Facility
Barranco & Sons, P.A. 21. Signathre of Fu Severna Park Funeral Home Severna Park, MD 21146 495 Gov. Ritchie Hwy. Approximate Interval er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** List only one cause on each line /Medical Death Bupropion, Diphenhydramine, Veniafaxine, and Phenterwine intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical AMENDED item#23a,27,28a-f,perME,G856,6/8/06 TT X UNPENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of deliven 3b. Was decedent pregnant in the Day Live birth Fetal death 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I by \$ Yes 2 No 3 Probably 4 🗸 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of this certificate has performed? death? ✓ Yes 2 No 2 No ✓ Yes 26.Place of Death (Check only one) 25. Was case referred to medica Be Other<sub>4</sub> Hospital: 1 Nursing Home 5 Residence 6 🗸 Other: Scene DOA Inpatient 2 ER/Outpatient 3 1 V Yes After 1 28a Date of Injury (Month, Day, Year 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury the Hospital or Attending I Certification: Natural Yes 2X No Pendina subject ingested pills Fnd 5/22/2006 | Fnd 12:05 am within 24 hours after death Fo the Funeral Director: the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 303 Glen Burnie, MD water Way Apt in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 X Suicide Could not be determined (Specify) House Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 23, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD 31. Date filed (Month, Day, Year) gistrar's Signature State 2006 JUN 0 Registra

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			. For	State of Maryla	nd / Depa	artmer	nt of H	ealth a	and M	ental Hy	giene	
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	and **		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ocation						10d. Inside City Limits
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	eme eme	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Dece If Yes, spe	dent of His	spanic Orig	gin? (Spe , Puerto	cify Yes or No Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.
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and	be fill bd off	Be	17. Father's Name (First, Middle, Last)  Jessie Odom							(First, Middle, ubbar	Maiden Sumame)	
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Ē	nit Pages partment of li- cortant: If It- Injury or o		1 Burial 2 Cremation 3 □R 4 □Donation 5 □Other (Specify)	emoval from State S	t. Res	t Ce	emete	ery	5-2	7-06	Hanover,	Md.
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1 of	ding Physician: h. Atter this certitic funeral director.		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time or		28c. Injury Work				now injury occurred	еспу)
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Division	To the Hospital or Attending within 24 hours efter death.  To the Funerel Director: Attencompletely filled in by the fune.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	reet, factor	y, office		2	28f. Location (S City or Tox	Street and Number or I vn, State)	Rural Route Number,
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			30. Name and address of person who co	impleted cause of death (Ite	em 23a) (Type,	Print)	ORR	wis	Me	Choue	May 28	
(00)	⇒ Sta	ite	31. Date filed (Month, Day, Year)	2. Registrar's Sign	nature _	20/7	iern	le,	MI	- 260	610	
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29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  StepLank ortal, mo 25 License number 5 the the supplier of the cause (s) and manner as stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  StepLank ortal, mo 25 License number 5 the the supplier of the cause (s) and manner as stated.  29c. License number 29d. Date signed (Month, Day, Year)	5	or At after d Direct in by	ertifi	data and d	28e. Place of Injury - At hom building, etc. (Specify)	ie, farm, stre	et, factory, office		28f. Location (Stre City or Town,	et and Number o State)	or Rural Rout	e Number,
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State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  Registrar MAY 2.6 2006 A A Assalad	5/	1-1+1		Stephan Kotch, ms	25, E.A.	tista	Street	He VIS	town m	0 21-	142	
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** May 2006 3:15 A<sup>M</sup> Hilda G. Dasch /Medical 4c. County of Death 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3339 N. Chatham Rd Apt F Ellicott City Howard If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Yrs. July 24, 1924 Germany Director 214 30 4667 81 Usual Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Ptygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits rai', or itema 23a or 28a-f ehow Exeminer must be notified at 1 ☐ Yes 2 ☑ No Director Ellicott City Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3339 N. Chatham Rd. Apt F 21042 United States Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No If Yes, Give Year or Dates: Specify Completed by 3 ₩idowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Kaufmann Max Gruenebaum Elisabethe Henriette Kieser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12574 Clover Hill Drive West Friendship, MD 21794 Diana L. Smallwood/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State Lorraine Park Cem. 5-23-2006 Baltimore, MD ⁴ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 J. 4112 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Dea 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) es **Physician** /Medical Due to (or as consequence of): Examiner ORONA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner The law requires that the death certificate be executed COR Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. the attending physician Physiclan/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 🖾No 9 Unknown detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be 3 ☐ Probably 4 ☐ Unknown 2 No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 ( X No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient ٩ 3 DOA 4 Nursing Home 5X Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 [] Homicide within 24 hours To the Funeral 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 May 22, 2006 30. Name and address of person who completed cause of death (tr m 23a) (Type, Print) KULUDRY 15E7 31. Date filed (Month, Day, Year) State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** lianan 1030 AM lau ennie 200lo /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗓 F 81 228-22-5487 Director Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 X No Director Anne Arundel Riva 10e Street and Number 10f Zio Code 10g. Citizen of What Country? ö 3048 Tudor Hall Road 21140 238 USA Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or Items 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: Specify Completed by 3 X Widowed 4 □ Divorced naturel 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: If item 27 Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Administrative Personnel Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Bridges Mimie Davis ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Dignan (Daughter) 3048 Tudor Hall Road, Riva, MD 21140 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State rtment of I rtent: If it njury or o 1 XBurial 2 Cremation 3 Removal from State Importent: I eny injury o \* 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vet. Cem. 5-19-2006 Crownsville, MD permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** lda intracromal resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, heading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for sels coneacuones off: Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Yes 2 No P.O. | signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably been 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has irector, page 2 s 1 ☐ Yes 2 🗷 No or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Appatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Medical Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide within 24 hours a To the Funerel I. filled To the Hospitel 뀬 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of Gertifier 29d. Date signed (Month, Day, Year) 29c. License number 024804 who completed cause of death (Item 23a) (Type, Print) Anagodi 31. Date filed . Registrar's Signature State Registrar

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	Funeral Director		5. Social Security Number 6. 218–40–9764  Usuef Residence of Decedent	1 □ M 2 137 E	ge (in yrs. ii 64	ast birthday) Yrs.	If Under Months	Days	If Under a	Min.	8. Date of (Month, 5/15	Birth Day, Yea /194	r) 9. 2 1	Birthple Country Mary	ce (State or F y) land	=oreign
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P.O. Box 68760,	the death certific by the attending p ached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🛣 No 9 □ Unknown	d	2  Fetal t time of de	death 3 ☐ ath 5 ☐	Ectopic pre	city)					23d. Date of Month	delivery Da	ау Үөа	hr
	w requires that been signed I should be det	by	Part II. Other significant conditions	contributing to death b	out not resul	lting in the ur	nderlying ca	use giver	n in Part I.				use contribut			
al Records,	or Attending Physician: The law requence dearth death. Director: After this certificate has been in by the funeral director, page 2 should	Completed									24a. We aut per	opsy formed?	prior	to comp	y findings ava letion of caus ☑ No	ulable se of
Ę.	Attending Physician: Ir death. ector: After this certifics by the funeral director, I	Be	25. Was case referred to medical examiner?	Hoopital				0.1		of Death	(Check only	one)				
of	this a	ဥ	1 ☐ Yes 2 ☐ KNo	Hospital:		R/Outpatient			4   (40)	-			6 □Other (5	Specify)		
Ē	ing F	on:	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Inju (Month, Da	y Yeer)	28b. Time of Injury		c. Injury			8d. Describe	how inju	iry occurred			
sio	tend leath tor: / the f	cati	2 Accident investigation 3 Suicide 6 Could not to	ne -			М		es 2□N							
Division of Vital	after death Director: in by the	Certification:	4 Homicide determined	28e. Place of in	ury - At hor c. (Specify)	ne, farm, stre	et, factory,	office		2	8f. Location City or T	(Street a	nd Number or e)	Rural R	oute Number	;
	urs a															
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier 1   (Check only one)  1   Certifying P  2   Medical Exa	nysician: To the best miner: On the basis of	f examination	rledge, death on and/or inv	occurred a estigation, i	t the time in my opi	, date and nion, death	l place, ai occurre	nd due to th d at the time	e cause(s e, date ar	and manner d place, and	r as state due to th	ed. e cause(s)	
	To the P within 2- To the F complete	Mec	29b. Signature and title of certifier	and manner st	a180.			License					ate signed (M			
)	F 3 F 8	7	· m/n	71								~5U. D	<b>*</b> /	/	, rear)	
	6 n		Imy p.	pr/				756	557	0			1/22	100	ò	
(	mp		30. Name and address of person who					-	,							
2			Ronald P. Travitz			versi		. , Sa	alisb	ury,	MD 2.	1801			<u> </u>	
200	Sta Registr		31. Date filed (Month, Day, Year)	2006	AS A	J. A.	mile									

		1 - For State Registrar	State of	Marylan		artmen rtificat			and M		giene,	2006	5 17818
Physi	ician	Decedent's Name (First, Middle								Date of De.     Month	Day	Year	3. Time of Death
/Me	dical	LEONARD		ABRACK	JR.	45 00	T	1	4 Danib	MAY	15	2006 county of Dea	7:30 P <sup>M</sup>
Exan	niner	4a. Facility Name (If not institution 6210 60th PLA	-	iber)			VERD.	Location o	n Death				GEORGE'S
Funera		5. Social Security Number 577-72-7020		7. Age ( <i>ln yr</i> s. <b>53</b>	last birthday) Yrs.			If Under a	24 Hrs. Min.	8. Date of Bird 10/22/	h	9. Bi	rthplace (State or Foreign country)
		Usual Residence of Decedent											
arylan ehow		10a. State 10b. County	1		y, Town or Lo	ocation	_		-				10d. Inside City Limits  Yes 2 No
he Mi	ecto	MD Prince	e George's		· · · · · · · · · · · · · · · · · · ·	10f. Zip		iverd	ale		10a Citiza	en of What C	
with t	급	6210 60th Place				TOT. ZIP		737				U.S.A.	•
DESILITIOFE, INSTYIETIC Z I Z I 3-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23s or 28s-f show any injury or other treumatic event, the Medical Examinal must be nutified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	Armed For	2 [ <del>2]</del> No ө		Was Deced If Yes, spec		spanic Origin, Mexican	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		Black, Wh	erican Indian, ite, etc.
L 13-UU30 thin 72 hours af e. en "naturel", or Medical Exam	ted	15. Decedent	's Education		16a. Dece	dent's Usua	I Occupa	tion			16b. Kind	of Business	s/Industry
thin 7	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	kind of wor DO NOT us	e retired)		or worki	ng			
led will lygien her th	ပ်	12th	10		Ma	il Ha			d. N	/Fine 8414/		overnm	ent
ylaria buld be file Mental Hy arked oth	To Be	17. Father's Name (First, Middle,  Leonard Art)	•	ley Em	brack				1ine	(First, Middle,		erly	
and 2 sho alth and 127 le m er treum		19a. Informant's Name/Relationsl Sabrina Embracl								ale, MI			Zip Code)
of He		20a. Method of Disposition 1   ■ Burial 2 □ Cremation	3 □Removal from 9	21010	Place of Dispo emetery, crea	matory or o	ther place			ate	20c. Loc	ation - City o	r Town, State
Pag ment ment ent: I		4 Donation 5 Other (S	pecify)	Ft	. Linc	oln C	emete	ery 5	/22/	2006		twood,	
Dallimore permit. Pages 1 Department of He Importent: If item eny injury or oth	900g	21. Signature of Euneral Service	icensee							. Jenki Landove			
by 000, are be executed whistien and prize the burial-transit	ical Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a Due to (	Meta: or as a conseq	r Cirr		r Cai	ncer					Onset and Death
COIGS, P.O. BOX 08/ w requires thet the death certificate been signed by the ettending phys should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		irth 2 Feta ant at time of d	Ideath 3	⊒Ectopic pr ⊒ Other (sp					23	d. Date of de Month	elivery Day Year
ords, P. requires that een signed bi	<u>۾</u>	Part II. Other significant condition	ns contributing to de	ath but not res	ulting in the u	nderlying c	ause give	n in Part I.			bacco use		o the cause of death?
The law requires to the law requires to the law requires to the law been signal page 2 should be	Completed									24a. Was autop perfor 1 🗆 Yes	an sy med?	24b. Were a prior to death?	
VICAL icien: 1 certifical rector, p	Be	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o			
OLI OLI Iling Phys After this uneral dii	은	1 ☐ Yes 2 XNo	28a. Date of (Monte	npatient 2 D	ER/Outpatier 28b. Time o Injury		8c. Injury Work	4 🗀 INUI	2	ne 5 Resid			ecity)
DIVISION  To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Afte completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ned 286. Place	of Injury - At hong, etc. (Specif	ome, farm, str	reet, factory	, office		1	28f. Location (S City or Tox		Number or R	lural Route Number,
To the Hoepital or within 24 hours afte to the Funeral Dir.	Medical (	29a. Certifier 1 Certifyin (Check only one) 2 Medical	g Physician: To the Examiner: On the ba and mann	isis of examina	wledge, deat tion and/or in	h occurred vestigation,	at the time in my op	e, date and inion, deat	d place, a	and due to the o	ause(s) a date and p	nd manner a lace, and du	s stated. e to the cause(s)
To th withir To th comp	M	29b. Signature and title of certifier	111	1			. License						th, Dey, Year)
6		tlanni (	Stilt 555.	- /10	C.		28079					/17/20	
(8)		30. Name and address of person Francine J Higg	S-SHITPMAH	II.D.			Belle	evue	Dr.	Beltsv	ille.	MD 2	0705
Regi	State strar	31. Date filed (Month, Day, Year)	. Re	egistrar's Signa	turo	Les							

/Medical P.O. Box 68760, Division of Vital Records,

Examiner attending physician and for use as the buriat-transit The law requires that the death certificate be executed should be peeu To the Hospital or Attending Physician: After death. within 24 hours after deat To the Funeral Director: in by t

**Physician** 

/Medical

Examiner

10a. State

MD

Director

Funeral

Completed by

Be

, Funeral

Director

Worls

rithen "neturef, or items 23a or 28a-f shoote Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 73.
Depurtment of Health and Mental Hygiene.
Important: if item 27 is marked other then "no any njury or other traumatic event, the Media page.

**Physician** 

death with the Maryland

filed within 72 hours after

Maryland 21215-0036

Baltimore,

Immediate Cause (Final resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Completed 25. Was case referred to medical examiner? Be 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0034722

Cheverly, MD.

State

Registrar

Driwin 17 Rev 1/200

31. Date filed (Month, Day, Year)

Vicken K. Poochikian, M.D. 3001 Hospital Dr.

2006

Name a address of person who completed cause of death (Item 23a) (Type, Print)

				partment of Health and Mertificate of Death	Mental Hygier	2 11111	-	820
	Physici	ian	Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of	Death
	/Media	ical	NAOMI W. FRANKLIN		05-29-2	2006	4:00	P M
	Examir	ner	4a. Facility Name (If not institution, give street and number) BEVERLY HEALTHCARE OF HAGERSTOWN	4b. City, Town, or Location of Death	1	4c. County of Death		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	HAGERSTOWN  y) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	WASHINGTO		
	Director		214-07-3322 1 M 2X F 91 Yrs.	Months Days Hours Min.	(Month, Day, Yea	ar) Cou		
	p ,		Usual Residence of Decedent		10-00-19	14 WEST	ERN PO	RT MD
	ehov	2	10a. State 10b. County 10c. City, Town or L	ocation		1	10d. Inside Cit	
	the M	Director	MD WASHINGTON HAGERST				1 X Yes	2 🗆 No
	hours atter deeth with the Maryland tural; or Items 23s or 28s-1 show at Exertirat must be redified at			10f. Zip Code	10g. (	Citizen of What Cour	ntry?	
	heeth ms 23	Funeral	750 DUAL HWY  11. Marital Status 12. Was Decedent Ever in U.S. 13.	21740 Was Decedent of Hispanic Origin? (See	4. V-a ar Na	US		
0	or Iter			i. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Americ Black, White,		
3	ral', o	þ		1 ☐ Yes 2 ☐ No Specify:		Specify: WH	ITE	
	72 ho	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation re kind of work done during most of worki	16b.	. Kind of Business/Inc	idustry	
7	within 72 ene. than "na na Medic	id m	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	3	YNTHETIC I	FIBER	
7	ljed w lygier lher ti			SICAL LAB TECH	M.	ANUFACTURE		
and	ntal F ed of	Be	17. Father's Name (First, Middle, Last)  CLERANCE W. WILT		e (First, Middle, Maide	en Sumame)		
جُ	2 should be tiled v n and Mental Hygie i e msrked other t reumatic event, III	2			D KLINE			
	s 1 end 2 should be tiled within 72 hours atter deeth with the Marylan of Health and Mental Hygiene. Item 27 ie marked other than "natural", or items 23e or 28e-1 ehow other treumatic event, the Medical Examinar must be restified at		(001)	ling Address (Street and Number or Rura				
ש	thealth tem 27 other tr		20a. Method of Disposition 20b. Place of Dispo	216 ANNA B STREET, Dosition (Name of		EHOBOTH BE Location - City or To		1 19971
5	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	ematory or other place)				
	그 문문을 .		WVO IIIIIO	PRIAL VAULT   06-0	1-2006 MC	ORGANTOWN	WV	
Ď	Depa Impo any ir		Blat 1 Black 1	WVU HUMAN GIFT REG	ĮSTRY			12
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	MORGANTOWN WV 26500 onter the mode of dying, such as cardiac or	or respiratory arrest,		Approximate	
1	Physician			Demenha			Interval Betw Onset and De	veen
!	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	12mer i in				
	Examiner							
	в <del>Ц</del>	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Examiner	resulting in death) Lest					
	se exe		Due to (or as a consequence of):					144
0	physic the t	dlcai	d			0		
<b>&gt;</b>	death certifical attending place as t	/Me	IF FEMALE:					
3	atten for us	Physician/Me	A December 12 in Original in the Control of the con	Ectopic pregnancy		23d. Date of deliver		
;	by the de	ysic	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown 9 Unknown	Other (specify)		WORLD	Day 16	9ar
	that the the the the the the the the the th		Part II. Other significant conditions contributing to death but not resulting in the ur	underlying cause given in Part I.	23a Did tobacco	use contribute to the	- cause of de-	-160
3	quires n sign ald be	0	PNEUMONIA, GASTROINTES	TIMM BLEED		_/	abiy 4∏Un	
	s been si should I	ompleted	Anemia			_		
-	The le sete has page 2	E O	71101100		24a. Was an autopsy performed?	24b. Were autop prior to com death?	psy findings av npletion of cau	allable use of
		O	25. Was case referred to medical		1□ Yes 20 N		2 No	
	ysic s ce direc	0 8	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 EP/Outpatien	26. Place of Death				
ó	ter thi	<del> </del>	27. Manner of Death 28a. Date of Injury 28b. Time of		ne 5 Residence 8d. Describe how inju		1	
. 7	Attending r death. ctor: After by the funer	Certification:	1	Work? M 1 ☐ Yes 2 ☐ No		.,		
	er de	tif	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stribuilding, etc. (Specify)	reet, factory, office 2	8f. Location (Street a	nd Number or Rural	Route Numbe	ar,
i ş			- Dulling, Stc. (Opecity)		City or Town, Stat	te)		
000	10sp 4 hou Funer ely til	ca	29a. Certifier (Check only and one)  Certifying Physician: To the best of my knowledge, death (Check only and manner stated)  And manner stated	n occurred at the time, date and place, ar	nd due to the cause(s	s) and manner as sta	ated.	
4	To the P within 24 To the F complete	Medical	and marinor stated.		d at the time, date an	id place, and due to t	the cause(s)	
T	Twit o		29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month, D	)ay, Year)	
			The state of the s	D0062327	5	13010	6	
			30. Name and address of person who completed cause of death (Item 23a) (Type, I					
4	Sta				MD 21	740		
	Stat Registra		31. Date filed (Worth, Day, Year) 32. Registrar's Signature	le s				

			1 - For Stata Registrar	State of Marylan				ealth a Death			Reg. No.	20	06	17821
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Louise W. Foley							2. Date of De Month May 17	Day		Year	3. Time of Death  11:00 a M
A STATE OF THE STA	Examin		4a. Facility Name (If not institution, give si					Location of	f Death		4c.		of Death	
32	<b>.</b>	- 2	Maple Ridge Group  5. Social Security Number 6. Sex	Home 7. Age (In yrs.	last birthday)		ckvi] er1Year	If Under 2		8. Date of Bi	rth	MC	9. Birth	omery place (State or Foreign
	Funeral Director		579-44-2022 Usual Residence of Decedent	M 254 F 80	Yrs.	Months	Days	Hours	Min.	eb. 22		26		yland
	ne Maryland 8a-f ehow	Director	10a. State 10b. County  Maryland Montgomer		y, Town or Lo	le.								10d. Inside City Limits 1 ☐ Yes 2 🙀 No
	with the		10e. Street and Number				ip Code					zen of V	Vhat Cou	ntry?
036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Iteme 23a or 28a-f ehow event, I'm Medical Exactinal must be notified at	by Funeral	15908 Maple Ridge  11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:				ispanic Orig in, Mexican, Specify:	gin? (Spec , Puerto R	ify Yes or No ican, etc.)		Blac	e Ameri k, White, White	
21215-0036	in 72 ho n "natur de alcal	Completed	15. Decedent's Educ (Specify only highest grade	completed)	16a. Dece (Give life.	dent's Us kind of w DO NOT	ual Occupa ork done o use retired	ation during most ()	of working	g	16b. Kii	nd of Bu	ısıness/In	ndustry
212	d with giene	No.	Elementary/Secondary (0-12)	College (1-4or 5+) 4	Ch	emis	t				Res	earc	h	
ō	2 should be filed and Mental Hygie is marked other raumatic event, II	o l	17. Father's Name (First, Middle, Last)  John H. Glick							(First, Middle McMul		Sumam	r <b>e</b> )	
Baltimore, Mar	permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any injury pt other traumatic evone.		19a. Informant's Name/Relationship (Type  John H. Glick, Jr  20a. Method of Disposition  QBurial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	./Brother  200. F	2007 Place of Disponentery, create of H	Hunt Desition (N. Matory or Leave 2. Name:	Mast arme of other place n Cen and Addres S J.	er La netery	May 200	22, 06 uneral	Silv	, PA cation - er S e Ir	A 193 City or T	342 own, State
			23a. Part1. Inter the disease, or complik shock, in heart failure. List only on Immediate Cause (Final	cations that a used the deat e cause on each line.								Spi	ing,	Approximate Interval Between Onset and Death
8760,	death certificate be executed  e attending physician and of for use as the burial-transit	dical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):									
.O. Box 6	death certific e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	ac. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	death 3	Ectopic Other (	pregnancy specify)				2	23d. Dat Mo	e of deliv	very Day Year
<u>a</u>	uires that n signed b	by	Part II. Other significant conditions con Alzheimer's Disease	-	-		cause give	en in Part I.						the cause of death? bably 4 🛣 Unknown
al Records,	ysician: The law requires that the is certificate has been signed by th director, page 2 should be detached	Completed								24a. Was auto perf 1 Yes	psy ormed?	, c	Vere auto prior to co death? Yes	opsy findings available ompletion of cause of
<u> </u>	sician: Th certificate irector, pag	o Be	25. Was case referred to medical examiner?	ospital:			Oth			Check only				Group
on of	ding Ph h. After th funeral		1 Yes 2 No  27 Manner of Death 1 Natural 5 Pending 2 Acceptant investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. Injun Wor	4 □ Nur y at k? Yes 2 □ N	28	e 5 Res	how injur	occurr	er ( <i>Speci</i> ed	My Home
Division of Vital		Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str y)						(Street and wn, State)		er or Run	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Dit completely filled in	edical (	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my known of the basis of examination and manner stated.	wledge, deat ition and/or in	h occurre vestigation	d at the tin	ne, date and pinion, deat	d place, ar th occurred	nd due to the d at the time,	cause(s) date and	and ma place,	nner as s and due t	stated. to the cause(s)
ı	To th Within To th compl	Me	29b. Signature and title of certifier			2	9c. Licens							Day, Year)
)	5		30. Name and address of person who co					32332	***	Cned				2006
3.40	Sta Regist		Suresh Gupta, M.D  31. Date filed (Month, Day, Year)  MAY 2 2 20	32. Pegistrar's Signa		nue,		, SII	ver	Phr.Tud	עויין ו			

		1 - State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artme <i>rtifica</i>	nt of H <i>te of L</i>	ealth and Death	Mental H	ygiene Reg. No.		1782
Physicia /Medic Examin	al	Decedent's Name (First, Middle, Las     NARY     4a. Facility Name (If not institution, give	ILEEN			UTK , Town, or	A Location of Deat	2. Date of E Month MAY	Day	Year  2006  County of Deat	
Funeral Director		219 44 0200		last birthday) Yrs.		er 1 Year	RE CITY  If Under 24 Hrs  Hours Min.		Day, Year)	Co	nplace (State or Fore untry) yland
72 hours after death with the Maryland natural', or Items 23e or 28e-1 show dical Examinat he notified at	Director	Usual Residence of Decedent  10a. State 10b. County  MD Howard		ty, Town or Lo		ty					10d. Inside City Limit
s 23a or 2	ral Dire	100. Street and Number  10021 Emily Fox C				ip Code 21042				zen of What Co	
ours after de rel', or Item Exemination	by Funeral	11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		f Yes, sp	edent of Hisecify Cubar	spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No Rican, etc.)		14. Race - Amei Black, White Specify: Wh	e, etc.
_ ×	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		16a. Deced (Give life. I	kind of w DO NOT	ronk done d use retired)	uring most of wor	rking		Otym Home	•
should be filed within and Mental Hygiene. marked other than matic event, Ing Me	To Be C	17. Father's Name (First, Middle, Last) William Gray		1101110			18. Mother's Nar	ne (First, Middl Le Derda	e, Maiden	Own Home Sumame)	3
and 2 stealth ar m 27 is		19a. Informant's Name/Relationship (7.  Joseph Flutka/Hi 20a. Method of Disposition	isband 206. F	19b. Mailin	Fmi sition (Na	ly Fo		Iral Route Num. Date	- Cit		21042
permit. Pages 1 Department of H Important: If its any injury or ot		1 Surial 2 Cremation 3 4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licens	St.	John 1	s Ce	meter	y 5/24	ry H. V	Vitzke	cott Cit	lly FH Inc
Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the deatine cause on each line.  a. HEMORRH  Due to (or as a conseq	h. Do not ente						tt City,	Approximate Interval Between Onset and Death
cate be executed  physicien and sthe burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. ADRENOCOF  Due to (or as a conseq  Due to (or as a conseq  d.	RTICAL uence of):		ARCI	NOMA				Trion(n
death certiff e attending d for use as	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	Ectopic (	pregnancy			2	3d. Date of deliv	rery Day Year
		Part II. Other significant conditions co	ntributing to death but not resi	ulting in the ur	nderlying	cause givei	n in Part I.			se contribute to	the cause of death?
i: The law requicate has been	Completed	pul militaria de la companya della companya della companya de la companya della c						24a. Was auto perf 1 Yes		24b. Were autoprior to condeath?	opsy findings availab empletion of cause of
hyei his c	ation: To Be	25. Was case referred to medical examiner? 1	lospital: 1 k Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ate of Injury 28b. Time of			26. Place of Dea  4 Nursing H  at  as 2 No	ome 5 ☐ Res	one) sidence 6 Other (Specify) s how injury occurred		(fy)
oltel or Attendurs after death	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street a City or Town, Sta				
To the Hospitel or within 24 hours after To the Funerel Dirticumpletely filled in I	Medicai	one)	sician: To the best of my kno ner. On the basis of examinal and manner stated.	wledge, death tion and/or inv	estigation	n, in my opi	nion, death occur	, and due to the rred at the time,	date and	place, and due t	o the cause(s)
2 2 2 2 3		29b. Signature and title of certifier  Morrisa Burriess  30 Name and address of present who are				c. License				signed (Month,	
Stat Registra	te	30. Name and address of person who control of the John Strain of the J	OHNS MOPKINS MOS 32. Ryptrar's Signa	PITAL	600 N	ORTH	NOLFE ST	KEET, EAL	Timos	E MAKYLA	תבוג סא

State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month FRANCIS FROHNHOEFER 1450 10M 05 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LOVENTIST HUSPITAL TAKOMA PARK WASHING-TON MONTGOMERY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 6. Sex Birthplace (State or Foreign Country) 1⊠M 2□ F 060-32-0920 Director 30,1939 New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene.
Important: if item 27 is marked other than "natural", or iteme 23a or 28a-f ehow any hjury or other traumatic event, the Madical Expir. or itematic profiled at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Virginia 1X Yes 2 □ No Alexandria 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 801 N. Pitt St. #1505 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Northern Virginia Elementary/Secondary (0-12) College (1-4or 5+) Professor Of Accounting Community College 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Francis J. Frohnhoefer Elizabeth L. Kent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barry Cain / Friend 1420 W. Abingdon Dr. Apt. 221 Alexandria, VA 22314 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 12 Burial 2 ☐ Cremation 3 ☐ Removal from State Middle Village, John's Cemetery 05/25/2006 New York

22. Name and Address of Facility Everly-Wheatley Funeral Home Signatu 1500 W. Braddock Rd. Alexandria, VA Cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ie cause on each line. Part1. Enter the disease, or compleshock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** SEPSIS resulting in death) /Medical Due to (or as a consequence of): Examiner MACT INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown After this certificate has been signed funeral director, page 2 should be def Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 Z No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ¥es 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after To the Funerel Dire 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NO 60319 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll Ave. Takoma Park, Maryland Darcie Hammer, MD 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar MAY 2 2 2006

		1. Decedent's Name (F	First, Middle, Las	st)					1	2. Date of Da			3. Time of Death
Physici /Medi		Gareth LaR	ue Gree	nwood					]	Month May	16 Day	2006	11:10 A M
Examir		4a. Facility Name (If no	ot institution, give	e street and number)			4b. City, Town	, or Location o	f Death		4c. Co	ounty of Death	1
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Funeral		5. Social Security Number 166-22-682		- 27	∍ (in yrs. <del>10</del> 7'	last birthday) 7 Yrs.	If Under 1 Year Months Day		Min. A	B. Date of Birt (Month, Da	1929 YO <sup>Yea</sup> ()	9. Birth	place (State or Foreign intry) sylvania
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how		10a. State 10	0b. County		10c. Cit	y, Town or Loc	cation						10d. Inside City Limits
Ba-f e	cto		Oorchest	er	Ea	ast New	Market						1 ☐ Yes 2 🛣 No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Marulcal Examinar must be notified at once.	Funeral Director	10e. Street and Number 3506 Green		Pood			10f. Zip Code	1631				n of What Cou	intry?
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al', o	þ	3 XWidowed 4	Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2🖾 N	o Specify:			Sp	pecify: Wh	ite
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) **Physician** 12:49 AM May 21, 2006 William Albert Gooslin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Prince George's Clinton | CTTTLUTI
| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (Str. Country) | Aug. 31, 1931 | Kentucky 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F 578-40-3073 74 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "naturel", or Iteme 23s or 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Charles Hughesville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14195 Robey Drive 20637 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 [X]Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ģ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electrician-Owner/Operator Electric Company permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If Item 27 is marked other eny injury or other treumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lando Gooslin Annie Perry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14195 Robey Drive, Hughesville, Maryland, 20637 Margy Gooslin / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 25 1 Burial 2 □ Cremation 3 □ Removal from State Trinity Memorial Gdns 2006 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Squeral Service Licensee 22. Name and Address of Facility 3035 Old Washington Road M01391 Huntt Funeral Home POB 156, Waldorf, MD 20604 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PULMONIMPY DISEASE **DBSTRUCTIVE Physician** CHRONIL 10 YRS /Medical Due to (or as a consequence of): Examiner Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of Examiner certificate be executed use as the burial-transit and Due to (or as a consequence of) Box 68760. been signed by the attending physicien should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Cluknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à of Vital Records. CORONDA ARTER 3 Probably 4 □Unknown DISEASE 1 ☐ Yes 2 ☐ No Completed DIMBETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes → No 24a Was an certificate has blirector, page 2 s THROM BOCTTO 1 Yes 2 No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 patient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To Sich funeral 28a. Nate of Injury (Month, Day Year) 27, Manner of Zeath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Division 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. at or Attendi s after death ! Director; A d in by the fi 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 T Homicide within 24 hours a To the Funerel L Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatore and title of certifier 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 1cc/NJON 186 NELSON BENJERS 9131PISCATAWAY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 3 2006

			1 - For State Registrar	State of M	Maryland	l / Depa <i>Ce</i>	artmen rtificate	t of H e of L	ealth a Death	and Mo		iene <sub>g. No.</sub>	06	178	326
	Dhysiai		1. Decedent's Name (First, Middle, Las	st)							2. Date of Dear Month	th Day	Year	3. Time o	f Death
197	Physici /Medio		Robert William Hoeg								May 20,			6:20	a M
	Examir	er	4a. Facility Name (If not institution, give		•				Location			2.2	inty of Death		
1			Arcola Health & Reha  5. Social Security Number 6. S			et highday)	If Under		Sprine If Under		8. Date of Birth		ntgomery		or Comina
e,	Funeral Director			<b>X</b> M 2□F	Age (In yrs. Ia <b>84</b>		Months	Days	Hours	Min.	(Month, Day,	Year)		place (State of try)  W Jerse	
i.	to the state of		Usual Residence of Decedent							U	ec. 20. 1	1921	146	w Jerse	= <u>y</u>
	yland		10a. State 10b. County		10c. City,	Town or Lo	cation						1	0d. Inside C	-
	B Mar	ctor	Maryland Mon	tgomery	Si	lver Sp	pring							1 🗌 Yes	2 <b>X</b> No
	ith th	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen	of What Cour	ntry?	
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	ltemi	Funeral	11. Marital Status 1 □ Never Married 2 ★ Married	12. Was Decede Armed Force 1 X Yes 2[	s?	. 13.	Was Deced If Yes, spec	ent of His	spanic Ori n, Mexicar	gin? (Spec 1, Puerto F	offy Yes or No- Rican, etc.)		Race - Americ Black, White,		
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21215-0036	72 hous after death with the Maryland natural', or Itema 23a or 28a-f show disal Examination to be natified at		15. Decedent's Ed	ducation		16a. Dece	dent's Usua	al Occupa	ation	t of working		16b. Kind o	f Business/In	dustry	
215	en "n	ρle	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4d	or 5+)	life.	kind of wor DO NOT us	e retired,	)		ig .				
2	ed wi	Completed	12			Non-(	Commiss	sionec				U.S.	<del>-</del>		
nd	tal High	Be	17. Father's Name (First, Middle, Last)  Robert William Hoege					Ì		er's Name E. Fau	(First, Middle, I	Maiden Sun	name)		
3	d Mer marke marke	2	19a. Informant's Name/Relationship (			10h Maili	na Addraes	(Street a			Route Number	City or To	um Stato Zin	Codel	
Maryland	d 2 s th an th an t7 is t		Nina Hoeger/ Wife	1900, 1711119	1		-				ver Sprir	-		70000)	
	permit. Pages 1 and 2 should be lited within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Itema 23a or 28a-1 show amportant: If item 27 is marked other then "natural", or Itema 23a or 28a-1 show injury or other traumatic event, the Mudical Examinet must be notified at once.		20a. Method of Disposition		20b. Pla	ice of Dispo	sition (Nan	ne of	0)	Da	ate	20c. Locatio	on - City or To	own, State	
OE.	nt: F	1	1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		116	metery, crei opolita				May 2 2006		1			
altimore,	partm ports / inju	1	21. Signature of Funeral Service Licer		1	22	2. Name an	d Addres	s of Facili		l Home In		ria, Vi	GEHA	
Ö	Depa Impo		I (inchen)	J_Cole	,						ilver Spr		D 20901		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caus one cause on each	sed the death.					cardiac or	respiratory arr	est,		Approximation Interval Bet Onset and	tween
	Physician		tmmediate Cause (Final disease or condition resulting in death)	J a	SEPS	15 J	YND	no	ME				William Control	Criset and	Death
	/Medical Examiner		resulting in death)	Due to (or	as a conseque										
		70	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or	as a conseque	ence of):	V//4			-					
	uted I	Examine	Cause (Disease or injury		, , , , , , , , , , , , , , , , , , , ,										
Ć.	sician and burial-transit	Еха	that initiated events resulting in death) Last	Due to (or	as a conseque	ence of):					·				
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Вох	eath certific attending pl	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor 1☐Live birth	me of pregnan 2  Fetal o		∃Ectopic pr	egnancy					Date of delive	_	Year
G.	ne dea the at hed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant 9☐ Unknown	tat time of dea	ath 5	Other (sp	ecify)					MONTH	Бау	1 oai
P.O.	that the de ed by the detached	Phy	Part II Other significent conditions of	ontributing to deat	h but not resul	ting in the u	nderlying c	alise dive	n in Part I		23e. Did tol	nacco use c	contribute to the	ne cause of o	death?
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ta	ician: Th certificete rector, pag	ပိ	25. Was case referred to medical		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					of Death	Check only on	NO NO	1 🗆 Yes	2 🗆 No	
<u> </u>	Physician: this certificated fire the control of th	OB	examiner? 1 ☐ Yes	Hospital: 1   Inpa	atient 2 🗆 E	R/Outpatie	nt 3 DO	A Othe			ne 5 🗆 Reside		Other (Specif	y)	
0	ding Ph J. After th funeral	n: T	27. Manner of Death	28a. Date of I	njury Day Year)	28b. Time o	1 2	8c. Injury Work			8d. Describe ho				
Sio	Attending ir death. ector: After by the fune	atic	2 Accident investigation	n			М		Yes 2□						
Division of Vital Records,	or Att after d Direct in by t	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	289. Place of	Injury - At honetc. (Specify)		reet, factory	r, office		2	8f. Location (St City or Town		imber or Rura	il Route Nun	nber,
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	dical		ysician: To the be niner: On the basis and manner	s of examination										s)
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	0''		1			23а) (Туре,	Print) 52	17A1	MSU	MAK	LRAJ	AW.			
			30. Name and address of person who				5:10)	, 0	LM	4,	MD: 2	0832			
9	Sta Regist		31. Date filed (Month, Pay, Year)	2006 32. 109	istrar's Signatu	Ire	certis	l		5//5/		55.			

# Please Type or Print in Black Indelible Ink

hn Hebert		State of Maryland / Dep	ertificate of		ı ivlental H		200	6 1782
Physic	ian/	Registrar  1 Decedent's Name (First, Middle,Last)				Date of Death     Month	Day Year	3 Time of Death
edical Exam	iner	John Douglas Hebert  4a Facility Name (if not institution, give street and number)	- 4	b. City, Town, or I	ocation of Death	May 28, 20	4c. County of Death	1310 hrs
		University Hospital		Baltimore Ci			Baltin	more
Funera		5. Social Security Number 6. Sex 7. Age (In yrs	last birthday)	If Under 1 Year Months Days	If Under 24Hrs Hours Min	_	(MM/DD/YYYY) 9. Birt Foreigi	
Director			0 Yrs	Months Buys	110010	07/05/	1955 Co.	intry) MD
ıny		Usual Residence of Decedent           10a. State         10b. County         10c. Ci	ty, Town or Location	on .				10d. Inside City Limits
Maryland 28a-f show any d at once.	ا ا	PA York	Stewa	rtstown	1			1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number		10f. Zip Code		100	g. Citizen of What Coun	try?
ith the A 23a or notified	a D	75 Smokebox Circle  11. Marital Status	11S 13 Was	1736 Decedent of His		pecify Yes or No-	USA 14. Race - Americ	ean Indian Black
eath wi items ust be	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Ye	es, specify Cuban,			White, etc.	sarrindari, oldon,
after d al", or	1 -1	3 Widowed 4 Divorced If Yes, Give Year or Dates.	1	Yes 2 X No				ite
hours natur Exami	ted t	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)		's Usual Occupati ost of working life.			16b. Kind of Business/li Transpor	
336 thin 72 te than '	Completed	8	Qualit	y Assu:	rance E	nginee	Technolo	
215-0036 be filed within 72 hours af mal Hygiene. Trked other than "natural ent, the Medical Examin	Con	17. Father's Name (First, Middle, Last)		1	18.Mother's Name	(First, Middle, M	aiden Surname)	
T	1 0	John R. Hebert  19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street		arie Ma Rural Route Numb	er, City or Town, State,	Zip Code)
a, MD 2 and 2 shoul tealth and 10 item 27 is in	-	Sandra A. Hebert/Wife					rtstown,	,
more, N Pages 1 and nent of Health		1 Burial 2 X Cremation 3 X Removal from State	<ul> <li>Place of Disposi crematory or oth</li> </ul>	er place)	Ju		20c. Location - City or	
altimore, mit Pages lar partment of Hee portant: If ite		4 Donation 5 Other Specify:	ork Count			06	York, PA	
Baltimore, MI permit Pages 1 and 2 s Department of Health a Important: If item 27, intury or other traum		21. Signature of Funeral Service Licensee  Mulaulaulaulaulaulaulaulaulaulaulaulaulau					nstein Mort stown, PA	uary, Inc.
Physician	_	23a Part I Enter the disease, or complications that caused the dea						Approximate Interval 8etween Onset and
/Medica Examine		failure. List only one cause on each line.  Immediate Cause (Final disease a Head Injuries with Col						Death
ZAGIIIIIO		or condition resulting in death)  Due to (or as a consequence	e of):					
	ner	Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause	e of):					
	Examiner	C. Due to (or as a consequence events resulting in death). Last	e of).					
and ecuted		d				-		
60, ate be execut hysician and	Physician/Medical	UNPENDED AMENDED	222222				23d Date of delivery	
Box 68760, e death certificate be ex	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pr 1 ☐ Live birth	2 Fet	al death 3	Ectopic pregna	ancy		ay Year
Box 6871 death certifice the attending p	Sici	4 Pregnant at time of Unknown 9 Unknown	death 5 Oth	ner (Specify)				
b.O. B that the d	l H	Part II. Other significant conditions contributing to death but no	ot resulting in the u	nderlying cause g	iven in Part I	23e. Did tob	pacco use contribute to	he cause of death?
b, P.O. irres that the signed by the detach.							2 No 3 Prob	′ 🗀
ords, w requir	plete					24a. Was a autops perform	y prior to c	topsy findings available ompletion of cause of
Rec The la	Completed			00.51	(F) 11 (OL 1	1 <b>✓</b> Yes 2		s 2 No
Division of Vital Records, rate or Attending Physician: The law requirers after death There has been sent in bring the short of the sho	Be	25. Was case referred to medical examiner?  1. Ves 2 No. Hospital: 1 Inpatient 2	ER/Outpatient		of Death (Check Other <sub>4</sub> Nursi		Residence 6 Other	:
of V og Phy offer th	7: To	27 Manner of Death 28a. Date of Injury	28b. Time of Ir	njury 28c. Injur	ry at Work?		ow injury occurred truck by auto	
ion ttendin death ttor: A	<u>≅</u>	1 Natural 5 Pending May 27, 2006 May 27, 2006 May 27, 2006	2203 hrs		res 2 ✔ No			
Division Spital or Attend hours after death meral Director:	Certification:	3 Suicide 6 Could not be determined (Specify) Local St		et, factory, office b	uilding, etc.	or Town, St	treet and Number or Ru ate) Oward Street, Balt	
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death this certificate has been signed by the attending physician and the Funeral Director Angel Fusion and Schoold he deached for use as the hursial I rans	၂ပ	4 Homicide  29a. Certifier 1 Certifying Physician: To the best of my knowl	ledge, death occur	red at the time, da	ate and place, and	due to the cause	e(s) and manner as start	ed
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	one) 2 Medical Examiner: On the basis of examination and manner stated.	n and/or investigat	ion, in my opinion	, death occurred	at the time, date a	ind place, and due to the	e cause(s)
P × P i	ž	29b Signature and title of certifier		29c Licens O.C.I			29d Date signed (Mor May 31, 2006	nth, Day.Year)
		30. Name and address of person who completed cause of death (II	lem 23a)		· · · · · · · · · · · · · · · · · · ·			
1/2	)	Zabiullah Ali, M.D. Assistant Medical Examin		n Street, Balt	imore, MD 21	1201		
	State	11 14 1 (1) (1)	nature					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Ma. 2006 Mary Estella HOWELL /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 ♥□ F 93 May 25 1912 Maryland Director 214-09-5213 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits Peges 1 and 2 should be filled within 72 hours after death with the Marylan nent of Heatth and Mental Hygiene.
snt: If Item 27 Is marked other than "neturel", or Iteme 23s or 28s-1 ehow 1ry or other treumatic event, the Medical Examinar must be notified at 10a State 10b. County 1 Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16612 National Pike 21740 **USA** by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced White Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Herbert Burgan Alice Bragunier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edgar Howell - Husband 16612 National Pike, Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Peges 1 Department of H Important: If tte any Injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/27/06 Rose Hill Cemetery Hagerstown, Maryland 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licenses COO 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Septic shock **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner pressure sacral ulcer Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of) Examine t la ulcer and cellulitis burial-transit Due o (or as a c sequence of). Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ed bluods hanical mitral valve 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed ronic strial fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? failure renal chronic 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physicien: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient ၉ 2 K ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 KNatural 1 ☐ Yes 2 ☐ No 2 Accident ofter death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Funeret Direct Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide to Centifying Physician: To the best of my knowledge ideath occurred at the time idea and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifer Medical (Check only one) 24 and manner stated within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D45563 eddar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 324 East Antietam Street, Suite 203, Hagers town, Maryland M. THEODORU, MD Kedu

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

25

**ORIGINAL** 

32. Registrar's Signature

			1 - For State Registrar		ylan	d / Departme <i>Certifica</i>	nt of Heal te of Dea		Mental Hy	giene Reg. No	UU	6	7 (	329
	Dhuaisi		1. Decedent's Name (First, Middle, La	married .		110			2. Date of De	aath Da	v )	eer	3. Time o	f Death
н	Physici /Medic		1 HELMA	LRENE		HAIL	23		MAY	27	-		1116	AM
	Examin		4a. Facility Name (If not institution, giv				y, Town, or Loca		٦	40	. County of	Death		
			THE JOHNS HO	PKINS HO	SPI	TAL 1	SALTIN							
	Funeral		5. Social Security Number 6. S		-	Month		Inder 24 Hrs. ours Min.	8. Date of Bi	th y, Year		9. Birth	olace (State	or Foreign
	Director			□ M 2 🗶 78	3	Yrs.			July 2	7, 1	927		yland	
	p v		Usuel Residence of Decedent  10a. State 10b. County		Oc. Cit	y, Town or Location							Od, Inside C	tity Limits
	shor	<u>_</u>	,											2 (XNo
	8a-f	Director	Maryland Howard		Mo	ount Airy				10 0				
	with t	ă	10e. Street and Number			101. 4	ip Code				tizen of Wh		ntry?	
	s 23g	rai	759 Long Corner			6 40 114 5	21771	0-1-1-0-10			J.S.A.			
	er de Item	nue	11. Marital Status	12. Was Decedent Ev Armed Forces?		.5. If Yes, sp	edent of Hispani ecify Cuban, Me	exican, Puert	pecify Yes or No o Rican, etc.)	D-	14. Race - Black,	White,		
36	within 72 hours after death with the Maryland ene. than "ratural", or llems 23a or 28a-f show fra Madical Exercities must be notilised at	by Funerai	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		1 ☐ Yes	2 No Spe	ecify:			Specify:	Tath	ite	
21215-0036	hou	edi	15. Decedent's E			16a. Decedent's Us	ual Occupation			16b. K	ind of Busi			
5	in 72	Completed	(Specify only highest gra	ide completed)		(Give kind of v	vork done during	most of wor	rking					
2	with than	E C	Elementary/Secondary (0-12)	College (1-4or 5+)		Domestic	Engine	0.25		0	. II.ama			
0	filed within Hygiene.		17. Father's Name (First, Middle, Last,	)		Domesere			ne (First, Middle		Home Sumame)			
au	ld be ental ked (	To Be	Henley Hopki	ne				Musa	Davis					
Maryland	shou mar mar	-	19a. Informant's Name/Relationship (			19b. Mailing Addre	ss (Street and N			er, City	or Town, St	ate, Zip	Code)	
S	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating must be notified at Appre.		Kenneth L. Haines	Hughand		759 Long	Corner	Road -	Mount	Δίν	w Me	rii I	and '	21771
ē,	Hea Hea tem othe		20a. Method of Disposition	ildsballd	20b. F	Place of Disposition (A	ame of	, koud,	Date		ocation - C			-1//1
2	ages ant of t: If i		1 MBurial 2 ☐ Cremation 3 ☐ 14 ☐ Dorlattee 5 ☐ Other (Specif			cemetery, crematory o plar Sprin		; *6***	125 106	More	- A -		Moser	المسما
Baltimore,	ortan		21. Signature of Funeral Service Lises	·	10		and Address of F		723700	MOU	IIL AI	Ly	Mary.	Land
Ba	Dep Impo any		Arrest L.	26. Mas	11 2	) Moles	worth-W	illiam	s P.A.,					
			23a. Part1. Enter the disease, or com	plications that caused the	ne deat	26401 h. Do not enter the m	Ridge of dving, suc	Road, ch as cerdiad	Damasc or respiratory a	us,	Mary1	and	Approxima	372 te
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.					, ,	·			Interval Be Onset and	tween
	Physician /Medical		disease or condition resulting in death)	a. MULTI		RGAN F	TILLIRE	-					14 DA	24.
	Examiner			Due to (or as a company SEPS)		uence or):							20 N	
		<u>-</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a		uence of):				-		-	20 0	7-
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687	ficate phy: s the			u										
×	that the death certifica ed by the attending ph detached for use as th	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of							23d. Date	of delive	erv	
Вох	atter I for	ciai	in the past 12 months?	1□Live birth 2 4□Pregnant at tir							Month			Year
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<u> </u>	Physician: The law requires that the death certifica this certificate has been signed by the attending phraid director, page 2 should be detached for use as it.	by Physician/Med	Part II. Other significant conditions	ontributing to death but	not res	ulting in the underlying	cause given in f	Part I.	23e. Did	obacco	use contrib	ute to ti	ne cause of	death?
Records,	uires n sigr								1 🗆	Yes 2	□No 3	☐ Prob	ably 4 🔀	Unknown
Ö	w requir been si should	Completed							24a. Was	an	24h We	re auto	psy findings	available
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⋚	eicia certi	00	examiner?	Hospital:		5000	Othon		th (Check only		• ===			
o	Phyer this ral di	. To	1 Yes 2 No 27. Manner of Death	1 Inpatient 28a. Date of Injury	باک	ER/Outpatient 3 1 1 28b. Time of	28c. Injury at Work?	☐ Nursing H	ome 5 Resi				V)	
on	ding I h. After funer	tlor	1. Natural 5 Pending	(Month, Day	(eer)	Injury M	Work? 1 ☐ Yes	2 🗆 No			,			
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Division of Vital	after Dire	erti	4 Homicide determined	building, etc.			,,		City or To	wn, State	9)			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Pt	nysician: To the best of	my kno	owledge, death occurre	d at the time. da	te and place	, and due to the	cause(s	and mann	er as s	tated.	
	24 h	edical	(Check only 2 Medical Examone)	niner: On the basis of e	xamina	tion and/or investigation	on, in my opinion	, death occu	rred at the time,	date and	d place, and	d due to	the cause(	5)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			2	9c. License num	ber		29d. Da	te signed (	Month,	Day, Year)	
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	5			COMPLETED COURS OF THE	th /lto-	n 23a) (Tuna Briet)	1 4			, 47	1 4	-1-		
	り		30. Name and address of person who CHRISTOPHER	REEVES A		n 23a) (Type, Print) MBA 600	Vir Prus III	VICI-	SHOP IN	RAM	MILION-	1/1/1	2. 4.4.5	7067
	Sta	to	21 Date filed (Month Day Vees)	2006 32. Ploistrar	s Signa	ature.	WILL W	ULFE.	STREET	CATC	INCHE	12/24	MENDE	LIZUT
	. Registr		MAY 24	2006 32. P distrar		No 19004								

State of Maryland / Department of Health and Mental Hygiene 0 0 5

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		•	For Stete Registrar	State of Maryland		tificate of L			ig. No.	טע	170	) ) ) (
*	Physicis	20	1. Decedent's Name (First, Middle, Last,					Date of Deat Month		Year	3. Time of	
	Physicia /Medic		PAUL EDWARD HOLL					05	_18	06	10:15	A M
	Examin	er	4a. Facility Name (If not institution, give			•	Location of Death		4c. County o			
	9 1	· .	Holy Cross Hospit		a faireth at a col	Silver If Under 1 Year	Spring If Under 24 Hrs.	8. Date of Birth	Montg		Ly place (State or	r Foreign
15 p.	Funeral Director		577 <b>-</b> 50-7078	7. Age (In yrs. las. 72	Yrs.	Months Days	Hours Min.	(Month, Day,		Cour	SC	
	and and		Usual Residence of Decedent  10a, State 10b, County	10c. City, 7	Town or Lo	cation				1	0d. Inside Cit	ty Limits
	Mary feb	ğ	DC	LI o	ahina	ton, DC					1 🏿 Yes	2 🗆 No
	the	Director	DC 10e. Street and Number	Wa	RITTIE	10f. Zip Code		1	0g. Citizen of W	hat Cour	ntry?	
	N with		3419 Clay Street	. NE		200	19-1422		Unit	ed S	States	
	deati	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp. Mexican, Puerto	ecify Yes or No- Rican, etc.)		- Americ	can Indian,	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or iteme 23a or 28a-f show any Injury or other traumatic event, the Medical Examination in cultied at once.	þ	1 ☐ Never Married 2 ☐ Married . 3 📆 Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No		,	Specify:			
2-0	72 ho	eted	15. Decedent's Edu (Specify only highest grad		16a. Deced	dent's Usual Occupa	ation during most of work	ing	16b. Kind of Bus	siness/In	dustry	
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<u> </u>	should Ind Men	2	Freelove Jeffries  19a. Informant's Name/Relationship (7)		10h Mailic	ng Address (Street a	Nancy	Hollis	City or Town 5	State Zin	Code)	
<u>a</u>	d 2 sl th an 7 le r traur					. H Street					3323,	
	1 and Health tem 27		Gloria Hackman/Sis	20b. Plac	e of Dispo	sition (Name of			20c. Location - 0		own, State	
0 0	ages ont of t: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	-	natory or other plac	1		0 1.1	1 1		
Baltimore,	permit. Pages Department of Minportant: If its any Injury or of Ones.		21. Signature of Funeral Service Licens	Wash	Na:	t'1 Cemet . Name and Addres	ery 05-26	y=06 rickland	Sultiar Funera	id, I 1 Se	MD rvices	. P.A
Ä	Depa Impo any I		· Erec D	Strikland		500 Aller						
	1 19		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death.							Approximate Interval Bety	9
	Physician		Immediate Cause (Final disease or condition	a Metastatic E	'eanh r	araal Can	cor				Onset and D	)eath
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68760,	tificate be executed ig physicien and as the burial-transit	Aedicai		d								
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<u>a</u>	s thet	by PI	Part II. Other significant conditions co	ntributing to death but not resulti	ing in the u	nderlying cause give	en in Part I.	23e. Did tol	bacco use contr	bute to t	he cause of d	eath?
Vital Records,	quire on sign							1 □ Ye	es 2□No	3 🗌 Prob	oably 4 🙀	Jnknown
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ta	rtifica	0	25. Was case referred to medical				26. Place of Deat		28			
<b>\</b>	Physician: rthis certifica ral director, p	To B	examiner? 1 □ Yes 2 🖾 No		R/Outpatier	nt 3 DOA Oth	er: 4 Nursing Ho	ome 5 Reside	ence 6 Othe	r (Specif	fy)	
n of	ding Physician: The lav h. Atter this certificate has funeral director, page 2		27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Injury 2 (Month, Day Year) 2	8b. Time o Injury	f 28c, Injun Wor	y at k?	28d. Describe ho	ow injury occurre	ed		
Sio		catic	2 ☐ Accident investigation			M 1 🗆	Yes 2 □No					
Division	를 를 들고	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, sti	reet, factory, office		28f. Location (Si City or Town		er or Hura	al Houte Num	ber,
	Hospital 24 hours a Funeral I		29a. Certifier 1 Certifying Phy	vsicien: To the best of my knowle	edge, deat	h occurred at the tin	ne, date and place,	and due to the c	ause(s) and mar	nner as s	stated.	
	• Hos 24 h • Fur letely	dicai	(Check only 2 Medical Exemone)	iner: On the basis of examinatio and manner stated.	n and/or in	vestigation, in my o	pinion, death occur	red at the time, d	ate and place, a	ind due t	o the cause(s	)
	To the living 2	Me	29b. Signature and title of certifier		/	29c. Licens	e number	2	9d. Date signed		-	
			Halen	of forther	-, r	MD D6	2488		5/18	106	9	
V	(5)		30. Name and address of person who o			Print)					2091	
1			Pratima Pathak, M	.D. Holy Cross	Hos	pital, 15	00 Forest	: Glen Ro	oad, Sil	ver	Sp., 1	MD
1000	Sta Regist		31. Date filed (Month, Day, Year) MAY 2 2 2006	732. Hegistrar's Signatu	bee	K)						

		•	For State	State of Marylan			of Health a	and Me		- 6	005	17	831
			Registrar  1. Decedent's Name (First, Middle, Last)			lillCale	UI Dealii		Date of De	Reg. No.		3 Tim	e of Death
7. "	Physici	an	RICHARD E	HAER	ENIEM	_		-	Month.	Day	200		143 M
F	/Medic		4a. Facility Name (If not institution, give		7001		wn, or Location of	of Death	03		ounty of De		(1)
A	Examin		Anne Arundel Medic			Annap					ne Arı		
	Funeval		5. Social Security Number 6. Sec		last birthday)	If Under 1 Y	ear If Under	24 Hrs. 8.	Date of Bir (Month, Da			irthplace (Sta Country)	te or Foreign
This J	Funeral Director		144-20-3001	M 2□F 76	Yrs.	Months D	ays Hours		$\overset{ ext{(Month, Da}}{ug.} 1^2$	4, 19	29 N	ew Jers	ey
	pu 🛌		Usual Residence of Decedent  10a. State 10b. County	10c Cit	ty, Town or Lo	ocation						10d. Inside	City Limits
	ehov ehov	ž											es 2X No
	the N	Funeral Director	Maryland Anne Aru	ndel	Anna	polis 10f. Zip Co	ode			10g. Citize	en of What (	Country?	
	with	ā		Unit 105		2140				_	d Sta	•	
	ne 23	era	11. Marital Status	12. Was Decedent Ever in U	.S. 13.		t of Hispanic Original Cuban, Mexican	gin? (Specif			4. Race - An	nencan Indian	1,
10	riter	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give					can, etc.)		Black, Wh		
Maryland 21215-0036	4 within 72 hours after death with the Maryland Jiene. 1 then "naturel", or Iteme 23a or 28a-f ehow I'ne Medical Evaruhermust be notified at	Ď	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀	No Specify:			S	Specify:	White	
5-0	72 hc natur	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece (Give	dent's Usual C	occupation done during most retired)	t of working		16b. Kind	d of Busines	s/Industry	
2	within ene. then "	ig I	Elementary/Secondary (0-12)	College (1-4or 5+)						C.	16 5	loyed	
2	filed withir Hygiene. other than		17. Father's Name (First, Middle, Last)	5+	Ad	vertis	<u> </u>	er's Name (F	First Middle			тоува	
and	d a b	Be c	Stephen Haefner					Mann			,		
7	d 2 should be th and Menta to marked traumatic ev	2	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Maili	ng Address (S	treet and Numbe			er, City or	Town, State	, Zip Code)	
Ma	C. (C) W		Helen B. Haefner /		802	Coxswa	in Way	Unit	105	Annan	olie	Mary 1	and 214
ē,	s 1 and 2 if Health item 27 i		20a. Method of Disposition	20b. F	Place of Disp	osition (Name matory or othe	of or place)	Date	е	20c. Loc	ation - City	or Town, State	and 214
9	0 0		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temovariiom State		Crema		5/20/2	006	Balt	imore	, Mary	l an d
altimore,	permit. Pag Department Important: i Iny injury o		21. Signature of Funeral Service Licens	e#/			Address of Facilit						
Ö	20 E 2 8		Michel 1	<u></u>	14	7 Duke	of Glou	ceste	r St.	Ann	apolis	s, MD 2	21401
			23a. Part1. Enter the disease, or complishock, or heart failure. List only o	lications that caused the dear	th. Do not en	ter the mode o	of dying, such as	cardiac or r	espiratory a	rrest,			Between
	Physician		Immediate Cause (Final disease or condition	. alz h	uin	reis	Din	earl				Onset a	nd Death
135	/Medical		resulting in death)	Due to for as a consec	quence of):	i	Direa					-	0
н	Examiner	_	Sequentially list conditions,	b	ww	~,	Juste	~1				\	yer.
	pa ≅	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	quence or):							A CONTRACTOR OF THE CONTRACTOR	_
_	and and Il-tran	хап	that initiated events resulting in death) Last	c	guence of):								
760,	te be executed ysician and ie burial-transit	caiE											
687	5 % 6			d									
Box (	leath certificat attending phy I for use as the	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn						23	3d. Date of c	lelivery	
B	death e atte d for	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 2☐Feta 4☐Pregnant at time of c		⊒Ectopic pregi ⊒ Other (s <i>peci</i>					Month	Day	Year
P.0	that the de led by the a detached t	hys	9 Unknown	9□ Unknown					1				
	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	by P	Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	underlying caus	se given in Part I	l.	23e. Did 1	obacco us		to the cause	
Records,	w require been si should b								1 🗇	Yes 2	No 3□	Probably 4	Unknown
ec.	e law re has be ge 2 sh	pie							24a. Was		24b. Were	autopsy findir o completion	igs available of cause of
	The I	Completed							1 Yes	ormed? 20 No	death		
Vital	yeiclan: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	[				e of Death (	Check only	one)			
of\	Q 5	ဥ	1 195 2 2200	Hospital: 1 Linpatient 2				ursing Home				pecify)	
n o	70 0 0	lon	27. Manner of Death  1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	M 280.	Injury at Work? 1 ☐ Yes 2 ☐		d. Describe	now injury	occurred		
isi	Attending it death. ector: After by the fune	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	nome farm st				f. Location (	Street and	Number or	Rural Route N	lumber.
Division	or A after Direct	Certification:	4  Homicide determined	building, etc. (Speci	fy)	1000, 1000019, 0			City or To				
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun			sician: To the best of my kn									
	ne Ho 24 h ne Fu	Medical	(Check only '2 Medical Examone)	iner: On the basis of examinand manner stated.	ation and/or in	nvestigation, in	my opinion, dea	ath occurred	at the time,	date and p	place, and d	ue to the caus	ie(s)
	To the To the To the Comp	Ž	29b. Signature and title of certifier	20/		29c. L	icense number	1200		29d. Date	signed (Mo	nth, Dey, Yea	1)
			muchan f	Of ent	a m		D 214	38		N	104	162	006
•			30. Name and address of person who c	ompleted cause of death (Ite	m_23a) (Type	Print)	E HG	CHI./A	AN	MAPI	121	MAZIN	411
<b>\$</b>		10	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	0 5~2	U 0/9	(TIWIT)	1 00	VIN C		1111111	10/
	Regist	ate rar		2006	K A	Book							

			1	For State Registrar	State of	Marylan		rtment of H		-	giene Reg. No.	06	17832
	×*.	Physicia /Medic	al	Decedent's Name (First, Middle, Last)     FRANCENA GIL      4a. Facility Name (If not institution, give s		NSON		4b. City, Town, or	Location of Dea	2. Date of De	30th	2006 ty of Death	
	*	Examin Funeral	er ×_	UNION H  5. Social Security Number 6. Sex	OSPI	TAL Age (In yrs.			K TON	s. 8. Date of Bin	CE h y, Year)	9. Birth	place (State or Foreign
	0	Director		216-46-5136  Usual Residence of Decedent  10a. State 10b. County		91 10c. City	Yrs.	cation		Feb 2	1915	Mass	achusetts  10d. Inside City Limits
	ith the Mac	or 28a-f si	Director	MD Cecil  10e. Street and Number		Che	esapea	ake City			10g. Citizen o		1 □ Yes 2 ☑ No intry?
	6 after death w	and Mental Hygiene.  Is marked other than "natural", or iteme 23s or 28s-f show summit ovent, the Medical Examinar must be notified at	Funerai	61 Front St.  11. Marital Status  1 Never Married 2 Married	12. Was Deced Armed Ford 1Yes 2 If Yes, Give	es?	l1	21915 Vas Decedent of Hi Yes, specify Cuba  □ Yes 250 No	ispanic Origin? (	Specify Yes or No no Rican, etc.)		ace - Amer ack, White	ican Indian, , etc. nite
	15-003	n "natural",	Completed by	3 XWidowed 4 Divorced  15. Decedent's Edu (Specify only highest grade	Year or Date cation completed)		16a Deced	ent's Usual Occupion of work done of NOT use retired	ation	orking	16b. Kind of		
	and 212	ntal Hygiene ed other tha	Be	17. Father's Name (First, Middle, Last)  Edwin Gill	College (1-4	+OT 5+)	НС	memaker		ame (First, Middle,	Maiden Suma	Home	e
	laryla	and Mer ls marks	ပ	19a. Informant's Name/Relationship (Ty		925		g Address (Street	and Number or F	Rural Route Numbe	er, City or Tow		p Code)
	Baltimore, Maryland 21215-0036	penium rages ranks abloated by mean within 12 mous and boats with the penium in the maryim begantiment of Hastih and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iteme 23s or 28s -f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Judith Johnson  20a. Method of Disposition  1		20b. P	lace of Dispo emetery, cren	34th St sition (Name of natory or other place emation	xe)	and, CA Date 2/06	946 20c. Location Smyr:	n - City or T	
	Balti	Departn Departn Imports any inju		21. Signature of Funeral Survice 1, pass		M005	10 Ga	8 West	neral Cross	St. Gal	ena,	hen i	L. Schaech 21635
		hysician /Medical		23a. Part1. Enter the disease, or compli- hook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each	LZE1	MER'S		g, such as cardio		rest,		Approximate Interval Between Onset and Death
		xaminer	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	, F	r as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of a consequence o	IAL			ATION			
Y W	x 68760, G	physician and sthe burial-transit	ical Examiner	cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (o	CON/	ARY uence of):	ARTE	RY F	)156AS	Ł,		
JO	O. Box 68	the attending physical stress that the action of the control of th	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 M No 9 □ Unknown		th 2 ☐ Feta nt at time of d	death 3	Ectopic pregnancy Other (specify)	HW.			Date of deliver	very Day Year
-RAN	Records, P.O. Bo	wiequiles lital lite de been signed by the a should be detached f	b	Part II. Other significant conditions cor	atributing to dea	ith but not res	ulting in the ur	derlying cause give	en in Part I.		obacco use co res 2 🗆 No	ntribute to 3 ☐ Pro	the cause of death? bably 4 Munknown
Z	Il Reco		Completed							24a. Was autor perfo 1 ☐ Yes	an 24b osy rmed? 2 No	were aut prior to o death? 1 \( \text{Yes}	opsy findings available ompletion of cause of 2 No
0	f Vita	After this certific funeral director,	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	lospital: 1 Inj	patient 2	ER/Outpatien	3 DOA Oth		eath Check only on Home 5 Aesi		ther (Spec	ify)
SMHQ	Division of Vital R	death. ctor: After this y the funeral di	Certification;	27 Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of (Month)		28b. Time of Injury		yat k? Yes 2 □ No	28d. Describe			
10 H	Divi	rs after d al Direct led in by	Certifi	4 Homicide determined	28e. Place of building	of Injury - At ho g, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location ( City or To		nber or Rui	al Roule Numbèr,
1	] leticoott ed	vithin 24 hours after de to the Funeral Directicompletely filled in by the total completely filled in by the total completely filled in by the total completely filled in the total completely filled in the total completely filled in the total completely filled in the filled in the total completely filled in the filled in th	ledical	29a. Certifier 1 Certifying Physical Check only 2 Medical Examione)	sician: To the b ner: On the bas and manne	is of examina	wledge, death tion and/or inv	restigation, in my o	pinion, death occ	curred at the time,	date and place	and due	to the cause(s)
		with To T	Σ	29b. Signature and title of certifier	logi n	∩·D ·		D 5	9398		29d. Date sign		12006
-	_	10		30. Name and address of person who or ALOK RUSTO	41, M				PITAL	, ELX	TON,	, MI	ARYLAND.
		Sta Registr		31. Date filed (Month, Day, Year)  JUN 0 6 2006	39. Re	gistrar's Signa	ture	de la					

DHMH 17 Rev 1/2001

#### 06-03515

Natalia Yaaserwaa Joseph

#### Please Type or Print in Black Indelible Ink

1 10000	, po o	
State of Maryland	/ Department of Health and Mental Hygiene	

		1- For State Registrar		Certificate o	f Death		Reg	No 20	06 1783
Physici Medical Exam	GII I/	Decedent's Name (First, Middle,L		A TOOL	DII	1	2. Date of Death  Month  D	ay Year	3 Time of Death 0730 hrs
rese	IIIGI	NATALI  4a. Facility Name (if not institution,		A JOSE		Location of Death	May 24, 200	4c. County of I	Death
		Washington Adventist H	ospital		Takoma Pa	rk		Montgome	
Funeral		Social Security Number     6.	Sex 7. Age (In y	rs last birthday)	If Under 1 Yea  Months Day		8. Date of Birth (I		9. Birthplace (State or oreign
Director		212 13 0102	M 2XF	Yr			DEC. 8,	2005	Country WASH. D.C
any		Usual Residence of Decedent  10a. State  10b. County	10c. (	City, Town or Loca	ition				10d Inside City Limits
* .		MD. MONTGON	MERY	TA	KOMA PAR	K			1 X Yes 2 No
ne Maryland or 28a-f show fied at once.	Director	10e. Street and Number			10f. Zip Code		10g	Citizen of What	Country?
the A		670 FAIRVIEW	AVE.			912		U.S.A	
th with tems 2 st he n	Funeral	11. Marital Status  1 X Never Married 2 Marr	12. Was Decedent Ever ied Armed Forces?			spanic Origin? ( Spe n, Mexican, Puerto F		14 Race - A White, e	American Indian, Black, etc.
ter dea ", or it			1 Yes 2 X N		Yes 2 X No	specify:		Specify I	BLACK
ours af atural	d by	15. Decedent's Education (Specify	only highest grade complete	d) 16a. Decede	nt's Usual Occupa	tion (Give kind of we		6b. Kind of Busir	
6 172 hc au "ng cal Ey	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5+)	- during i		DO NOT use teche	50)		
5-0036 led within 72 Hygiene. other than the Medical	l mo	0 17. Father's Name (First, Middle, La	pet)		NONE	18 Mother's Name (	(First Middle Mai	NON	NE
ore, MD 21215-0036  ges 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Tifem 27 is and Mental Hygiene. Tifem 27 is and dother than "natural", or items 23a or 28a-f she they reaunatic event, the Medical Examiner must be notified at once	Be C	ROAN	JOSEPH			VAM		ENA BOA	AFO.
2121 ould be fi d Mental I s marked iic event,	70 6	19a Informant's Name/Relationship		19b Mailir	ng Address (Stree	et and Number or Ru			
<b>∑</b> ggggg		MAVIS A. BOAFO	O-JOSEPH/MOTHE		FAIRVIEW sition (Name of ce	AVE., TA			20912 ity or Town, State
Baltimore, bermit Pages I an Department of Hea Important: If iter		1 X Burial 2 Cremation	3 Removal from State	crematory or o	ther place)				
time t. Pagi timent riant:	$ \lambda $	4 Donation 5 Other Spec		The second secon	The state of the s	CEM. MAY			
Baltimo permit Page: Department o Important: injury or oth	0	21. Signature of Funeral School Lin		мооо 9 1 5	HAMBERS 1	FUNERAL H ELAND AVE	OME & CR	EMATORI DALE M	UM,P.A.
Physician		23a. Part I. Enter the disease, or confailure. List only one cause or	implications that caused the d	eath. Do not enter	the mode of dying,	, such as cardiac or	respiratory arrest	shock, or heart	Approximate Interval Between Onset and
/Medical	100	Immediate Cause (Final disease	a. Sudden unexila	ined death	in infancy	r			Death
LXummer		or condition resulting in death)	Due to (or as a consequent	ce of):					
	Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequen	ce of):					
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen	ice of):					
ecuted and - transit		events resulting in death) cast	d			···			
exe an a	edical	X UNPENDED	AMENDED item#2	3a,27,28a-	f,perME,g85	57 <b>,</b> 7/5/06 T	Γ		
, <u> </u>	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of		iotal death 3	Ectopic pregnar	nev	23d. Date of de Month	elivery Day Year
Box 68 death certiff the attending of for use as	icial	past 12 months?	4 Pregnant at time	- f al th	Other (Specify)		,		227
Bo ne deat the at	Physician/M	1 Yes 2 No 9 Unkno	9 Unknown	at the little of the		niver in Death	22a Did toba	and use contribu	ute to the cause of death?
i, P.O. B ires that the d signed by the I be detached	\$	Part II. Other significant condition	ns contributing to death but i	not resulting in the	underlying cause	given in Part i	1 Yes		Probably 4 Unknown
ds, cquires een sig	Completed						24a Was an		ere autopsy findings available
cords law requi has been e 2 should	l g						autopsy	ed? dea	or to completion of cause of ath?
cal Rection: The Coertificate Descriptions		25 Was case referred to medical	T		26.Place	e of Death (Check o	1 ✓ Yes 2 nnly one)	No1	Yes 2 No
Vital I hysician: this certifi	o Be	examiner?	Hospital: 1 Inpatient 2	≥ ✓ ER/Outpatie		Othor:		sidence 6	Other
ion of vending Pheath	n: 7	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b Time o			28d Describe how	v injury occurred	
sion trendi death rtor:	atio	1 Natural 5 Pendin 2 Accident Investi	gation Tite 5/ 24/ 200				unknown		
Division of Vital Records, P.O ispital or Attending Physician: The law requires that thour safter death meral Director: After this certificate has been signed by filled in by the fumeral director, page 2 should be deate	Certification:	3 Suicide 6 X Could			eet, factory, office t	building etc	Takona Pat	670 Faii	or Rural Route Number, City CVIEW AVENUE
D the Hospital hin 24 hours the Funeral		4 Homicide  29a Certifier 1 Certifying Phy	sician: To the best of my kno		urred at the time. d	date and place, and			
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death To the Functal Directory. After this certificate has been signed by the attending completely filled in by the functed director, page 2 should be detached for use as	Medical		iner:On the basis of examinat and manner stated						
F 3 F 3	₹	29b Signature and title of certifier	1/200-		29c. Licens				(Month, Day, Year)
		Carol	Adelai		O.C.	.M.E.		May 26, 200	· · · · · · · · · · · · · · · · · · ·
		30. Name and address of person w Carol Allan, MD Assi			Street, Baltim	nore, MD 21201	1		
	State		2006 32. egistrar's Si		ale				
Regi		3011 1	LUUU RAPERE	10 19					

			For State Registrar	State of I	Marylan		artmen rtificat			nd Me		giene Reg. No.	2006	17834
	Physici		Decedent's Name (First, Middle, La     P	st) AUL GORD(	ON JON	ES				1	2. Date of De Month MAY		Year 2006	3. Time of Death 5:20 P M
1	/Medi Examir		4a. Facility Name (If not institution, giv	e street and numb	er)		_	Town, or BETH	Location of ESDA	Death	HAI		County of Death	1
2.0	Funeral Director		5. Social Security Number 6. S 510-22-9995 Usual Residence of Decedent	ex 7.	Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Min.	3. Date of Bir (Month, Da 10/17/	y, Year)	Cou	nplace (State or Foreign untry) Ouri
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show amy injury or other traumatic evant, the Modical Examinar must be notified at once.	To Be Completed by Funeral Director	10a. State 10b. County Virginia Fairfax 10e. Street and Number  8712 Clydesdale R 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's E (Specify only highest grave) Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last) Paul Rowland Jone 19a. Informant's Name/Relationship ( Roberta K. Jones 20a. Method of Disposition 1 Daurial 2 Cremation 3 K 4 Donation 5 Other (Specifications) 21. Signature of Funeral Service Licer	12. Was Decede Armed Force Armed Force 112/Yes 2 1179s, Give Year or Date ducation College (1-4c) 2  S Type, Print)  / Wife	Spr	16a. Decedifie. I  16a. Decedifie. I  Vice  19b. Mailin  8712  Place of Disponemetary, cran  rfax M	1d 10f. Zip 221 Nas Deced f Yes, specif Ye	dent of Hicky Cubar of Young Cubar of American Cocuparity done of Servetired, Cocuparity done of Cocuparity done of Cocuparity dent of Cocuparity done of their place of th	Specify:  18. Mother's  Georg  nd Number  e Rd.	puerto Ri of working s Name ( ia Ro or Rural I Dat	First, Middle, DSE SC Route Number Cin fi	Uni  16b. Kir  Raca  Maiden  hreac  or, City or  eld, 20c. Loc	Sumame) des Town, State, Zi	ican Indian, etc. ite industry ian, Inc.
8760,	cate be executed between the permit of the pural integral of the pural-transit the burial-transit the burial-transit the principle.	dicai Examiner	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if driy, leading or immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. MUL Due to (or  SEP Due to (or  c.	TI ORO	h. Do not ente	902 Berthe mod	radd e of dying	ock Ro	d., I	neral   Fairfa: espiratory an	x . V	irginia	22032 Approximate Interval Between Onset and Death
P.O. Box 6	the death certifi y the attending iched for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions co	23c. If yes, outcon  1  Live birth  4  Pregnant  9  Unknown  ontributing to death	2 Fetal at time of de	Ideath 3 ath 5	Ectopic pro Other (spo	ecify)	n in Part I.			bacco us		Day Year he cause of death?
al Record	icien: The law requires that certificate has been signed b rector, page 2 should be deta	Completed									24a. Was a autop perfor	an sy	24b. Were auto	opposy findings available impletion of cause of
Division of Vital Records,	tending Physicath.	Certification: To Be	25. Was case referred to medical examiner?  1	28e. Place of I	njury Day Year)	ER/Outpatient 28b. Time of Injury	M 21	A Other  Bc. Injury  Work?  1 □ Y	· 4 🗆 Nursi	280	d. Describe h	ence 6 ow injury		iy) al Route Number.
)	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one)  2 Medical Exam  29b. Signature and title of certifier	and manner	of examinat	M.D	estigation,	License	nion, death number	occurred	at the time, c	late and p 29d. Date	signed (Month,	Day, Year)
100	Sta Registr		JOSHUA T. KINDEI 31. Date filed (Month, Day, Year)			ISN					MEDIO 0889-56		CENTER	

			1 - For State Registrar	State of M	larylan	-		nt of He <i>te of D</i>		id Me		ene2 (	06	17	835
	Dhusisi		1. Decedent's Name (First, Middle, Last,	)						2	Date of Death Month	Day	Year	3. Time o	f Death
*	Physicia /Medic	_	Ursel Miriam								lay 1		2006	12:20	) A. <sup>M</sup>
	Examin	er	4a. Fecility Name (If not institution, give			37	4b. City	, Town, or L		Death		4c. Count			
			5225 Pooks Hill R 5. Social Security Number 6. Se			N last birthday)	If Und	Bethe or 1 Year	saa If Under 24	Hrs. A	Date of Birth		ntgon	place (State	or Foreign
	Funeral Director			M 2 F	84		Months	Days	Hours	Min.	Date of Birth (Month, Day, lay 10,	Year) 1922	Gern	intry)	or rorong.
			Usual Residence of Decedent	A							.a.y 10,	1,22	001		
	how	_	10a. State 10b. County			y, Town or Lo	cation							10d. Inside C	
	e Ma Sa-f s	cto	Maryland Montgome	ry	Ве	thesda	.,								2 No
	2 should be filed within 72 hours after death with the Maryland and Menial Hygene.  In marked other than "natural", or Iteme 23s or 28s-f show aumatic event, the Madical Examinar must be notified at	Funeral Director	10e. Street and Number 5225 Pooks Hill Ro	ad Ant	108	North	10f. Z	ip Code 20814			10	g. Citizen of U。S		intry?	
	e 23e	rai		12. Was Deceden			Nac Doc			2 (Speci	fy Yes or No-			ican Indian.	
	Item Item	n n	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces	?	1	f Yes, sp	ecify Cuban,	Mexican, P	Puerto Ri	can, etc.)		ck, White		
336	ars af	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 🗆 Yes	2 No	Specify:			Speci	ty: Wh	ite	
Ş	2 ho	Completed	15. Decedent's Edu (Specify only highest grad			16a. Deced	dent's Us	ual Occupati	on ring most of	f working	1	6b. Kind of E	Business/Ir	ndustry	
21	thin 7	npie	Elementary/Secondary (0-12)	College (1-4or	5+)			rork done du use retired)	ning most or	HOINING		Ша	d		
2	filed within Hygiene. other than "	Con	8th Grade			веа	utic		0.44.4.4	<b>*</b> 1	5: 11:	На			
Maryland 21215-0036	be fill	Be	17. Father's Name (First, Middle, Last)  Max Rosenberg					1		a Is	First, Middle, M saak	alden Suma	me)		
<u> </u>	should ind Men marka umatic	P	19a. Informant's Name/Relationship (T)	mo Print!		10h Mailie	a Addra	s (Street an			Route Number,	City or Town	State 7	n Codel	
S S	d 2 st th and 7 le r traur		Dalia K. Gilpin -		r						t. 1619		Bet	hesda	MD.
	1 and Health Iem 27 other tr		20a. Method of Disposition	Daugnee	20b. F	Place of Dispo	sition (N	ame of		Dat		Oc. Location		0814 own, State	
ō	Pages nent of I		1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		8	dean M				-21-2	.006	01ne	v. Ma	ryland	l
altimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 Ie marks eny injuty or other traumatic engies.	. 1	21. Signature of Funeral Service Licens								Direct			_ <b>J</b>	
ñ	Ped of pe		Donald C. X	Stottle	mill	5 _ 1	001	Rocksti	11 <sub>0</sub> D	11/2	Rockyd	110 1		and 2	0852
Ь	9. 4.4		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that cause	ed the deat	h. Do not ent	er the m	de of dying,	such as ca	rdiac or r	espiratory arre	st,	iar y	Approxima Interval Be	te
	Physician		Immediate Cause (Final disease or condition	С	onges	tive H	eart	Failu	ıre					Onset and	
100	/Medical		resulting in death)	a Due to (or a											
	Examiner		Sequentially list conditions	A	ortic	Steno	sis								
	P ==	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consec	wante of).									
	ecute and -trans	Examiner	that initiated events resulting in death) Last	c. Due to (or a	e a consec	uence of):									
8760,	The law requires that the death certificate be executed sie hes been signed by the attending physician and bage 2 should be detached for use as the burial-transit	cal E		200 10 (0) 2	3 4 00,1000	,40.1.00 017.									
687	phys phys s the	edlc		d.											
Box (	eath certific attending p	₩.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom								23d. Da	ate of deliv	very	
ă	death a atter	Physician/M	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant			]Ectopic ] Other (	pregnancy specify)				М	onth	Day	Year
Р. О.	that the de ed by the detached	hys	9 ☐ Unknown <sup>X</sup>	9□ Unknown											
ις. Τ	res tha igned be det	by P	Part II. Other significant conditions co	ntributing to death	but not res	ulting in the u	nderlying	cause given	in Part I.		23e. Did toba	acco use cor	tribute to	the cause of	death?
ğ	w require been sig should b	edit									1 🗆 Yes	2 No	3 Pro	bably 4	Unknown
000	e law requ hes been je 2 shouk	Completed									24a. Was an autopsy		Were aut	opsy findings	available
Œ		E O									perform	ed? □ No	death? 1 ☐ Yes		
ita	ician: Th certificete rector, pag	Be (	25. Was case referred to medical examiner?			3001	14111111111111		26. Place of	Death (	Check only one	)			
×	hysic this co	၉	1 ☐ Yes 2 ☐XNo			ER/Outpatier			4 🗆 140131		5 X Resider		<u>`                                  </u>	ify)	
ū	ding P	in o	27. Manner of Death 1 Natural 5 Pending	28a. Date of In (Month, D	jury ay Ye <i>ar)</i>	28b. Time of Injury		28c. Injury a Work?		i	d. Describe how	w injury occu	rred		
sio	Attending Physician: Ir death. •ctor: Atter this certifice by the funeral director, i	icat	2 Accident investigation 3 Suicide 6 Could not be	One Place of I	oiun. At h	omo form et	M		s 2□No		f. Location (Str	eet and Num	bor or Pu	m I Pouto Nur	nhar
Division of Vital Records,	5 # iž :s	Certification:	4 Homicide determined	28e. Place of In building,	etc. (Speci	fy)	eet, racti	жу, опісе		20	City or Town,	State)	ver or nur	ai Houle Ivui	nuer,
_	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: Atter this certific completely filled in by the funeral director.		29s Certifier 1 X Certifying Phy	sician: To the bee	it of my kni	owledge; deat	n occume	d et tha time	date and p	otania, ari	d dua to the ear	rea(e) and it	William Se	stated	
	A Full	edical	(Check only 2 Medical Exam	iner: On the basis and manner:	of examina	ation and/or in	vestigation	n, in my opii	nion, death	occurred	at the time, da	te and place	, and due	to the cause(	s)
	To the within 2 To the complet	W	29b. Signature and title of certifier	0.			2	9c. License	number		29	d. Date sign	ed (Month	Day, Year)	
)	D		> Xnoeno	Flr	WE			M	D1192	4 (D	C) 1	May 17	, 200	)6	
	V		30. Name address of person who o			- 1									
			DR. STEVEN LERNER						, CHE	EVY C	HASE, N	ш 208	15		
*	Sta Regist		31. Date filed (Month, Day, Year)  MAY 2 2 20	106	strar's Sign	ature	arke	P							

			1- State of Maryland / Department of Health and Certificate of Death	Mental H	ygiene	6 17836
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of I		3. Time of Death
	/Medi		MARVIN LUTHER KLINE	MAY	23, 200	6 12:28P.M.
	Examir	ner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Dea		4c. County of [	
	Europel		REEDERS MEMORIAL HOME  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year  If Under 24 Hr			HINGTON Birthplace (State or Foreign
,	Funeral Director		217-16-2974 18 M 2 F 84 Yrs. Months Days Hours Min	s. 8. Date of E (Month, L APRIL	7, 1922	Birthplace (State or Foreign Country) MARYLAND
7	pu »		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			
>	death with the Maryland ms 23a or 28a-f show rmust be notified at	ō				10d. Inside City Limits 1X Yes 2 □ No
5	the A	Director	MARYLAND WASHINGTON HAGERSTOWN  10e. Street and Number 10f. Zip Code		10g. Citizen of Wha	
>	th with 23a or ust be	D	142 SUNFLOWER DRIVE 21740		U.S.	
7	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or N	No- 14. Race - /	American Indian, Vhite, etc.
MARN	or ite	by Fu	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No 1942 — 1 ☐ Yes 2 ☑ No Specify:	, to 1 hours, 6to.,	Specify:	
7 00	72 hours after dea "natural", or items	q pa	3 Widowed 4 Divorced Year or Dates: 1943		16b. Kind of Busin	WHITE
7 7 5	nin 72 in "na Medik	plet	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of w life. DO NOT use retired)	orking	TOD. KING OF BUSIN	ssamoustry
3 5	ad with	Completed	12 ELECTRICIAN		TRUCK MA	NUFACTURING
$\mathcal{M}_{INE}$ $\mathcal{M}$	be file tal Hy d oth	Be		100	le, Maiden Sumame)	
7 2	should nd Men marke	2		GUSTA CA		
_ E	s 1 and 2 should be filed within 72 hours after death with the Maryla f Healith and Mental Hygiene. I the file of the marked other than "natural", or items 23a or 28a-f shouther traumatic event, the Medical Examplest must be indiffered at		19a. Informant's Name/Relationship (Type, Print)  LAURA M. KLINE/SPOUSE  19b. Mailing Address (Street and Number or F		-	' '
ارا و	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once.		20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City	
VAME	Page nent o int: If iry or		Burial 2 Cremation 3 Removal from State	6/2006	BOONSBORO	MARYLAND
A interest	permit Departn Imports any inju		21. Signature of Charal Service Ligensee Paul m. Dean  22. Name and Address of Facility BAST FUNERAL HOME		old Nationa	
< "	207 2 29		" all the things are		oco, Maryl	and 21713
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	ac or respiratory	arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a.   Cancel Ca			oneyear
	Examiner		Due to (or as a consequence of):			0
	-	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	ate be executed hysician and the burial-transit	Examiner	that initiated events			
8760.	be exe ician a burial-		resulting in death) Last Due to (or as a consequence of):			
387	ate ohys	dical	d	-		
Box 6	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of	delivery
ă	death e atte	lcia	in the past 12 months?  1 Ves 2 No.  1 Pregnant at time of death 5 Other (specify)		Month	Day Year
0	that the dead by the detached	Phys	9 Unknown			
ø,	or Attanding Physician: The law requires that the death certificate death.  Director: After this certificate has been signed by the attending p in by the funeral director, page 2 should be detached for use as	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Drauetese well-tus			e to the cause of death?
oro:	w requir been si should	eted	Buttest Melutus			Probably 4 Unknown
Bec	The law	Completed		24a. Wa auto peri	s an 24b. Were prior death	autopsy findings available to completion of cause of a?
7	ician: Th certificate rector, pag	a	25. Was case referred to medical 26. Place of De	1 ☐ Yes	2 No 1 1	'es 2□ No
<u>&gt;</u>	Physician: this certific al director,	To B	examiner?		sidence 6 Other (5	pecify)
0	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury at Work? 28c. Injury at Work?		how injury occurred	
<u>.o</u>	ittendi death. stor: A	catl	2 Accident investigation M 1 Yes 2 No			
Division of Vital Records. P.O.	I or Attencater death	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Number or own, State)	Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled		29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place	e, and due to the	cause(s) and manner	as stated.
	the Ho hin 24 h the Fu npletely	Medical	(Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	surred at the time	, date and place, and	due to the cause(s)
	To t	Σ	29b. Signature and title of certifier  29c. License number		29d. Date signed (Me	
			D44996	)	May 23,	1006
,	0+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR. ZAFAR MALIK, 20311 LAPPANS ROAD, BOONSBORO, MARYL	AND 217	13 301_433	2-8470
<b>'</b>	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1/.	-001-408	- 5170
	Registr	- 6	MAY 2 4 2006 Janen B. Spersh			

	55		For State Registrar	State of Ma	ryland /		ment of H		F	Reg. No.	11115	17837
, ,	Physici /Medic Examin	al	Decedent's Name (First, Middle, Las     Arlene Kalata     4a. Facility Name (If not institution, give	1		4b	. City, Town, or		2. Date of Dea Month May	Day / 8 / 4c. C	Year 2006 Jounty of Deat	
	Funeral Director	it.	5 Smith Road  5. Social Security Number	7. Age	(In yrs. last b		Elkto Under 1 Year onths Days	n If Under 24 H Hours Mi			ecil 9. Bin 2 Indi	hplace (State or Foreign unity) an Lake, NY
	death with the Maryland ms 23a or 28a-f ahow	ctor	10a. State 10b. County  Maryland Cecil		10c. City, To	on						10d. Inside City Limits 1 ☐ Yes 2 No
	3a or 24	i Dire	10e. Street and Number 5 Smith Road				Of. Zip Code 21921				ed Sta	
030	urs after deatl ai', or itams 2 examinatina	by Funeral Directo	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates;		If Ye	Decedent of Hiss, specify Cubar	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	į	1. Race - Ame Black, Whit Specify: Wh	e, etc.
9500-61212	be filed within 72 hours after death with the Marylan Hygiene. I Hygiene. I dether than "natural; or items 23a or 28a-1 show to other than "natural; or items 23a or 28a-1 show avent, the Medical Examiner must be natified at	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12	ucation de completed) Colfege (1-4or 5-	.)	a. Decedent (Give kind life. DO I Homema	's Usual Occupa d of work done d NOT use retired; ker	tion uring most of v	vorking		d of Business, Home	Industry
Maryland	should be filed ind Mental Hygi is marked other umatic event, II	To Be C		anchard				Isabe		Porte	r	
	s 1 and 2 should of Health and Men item 27 is marke other traumatic		19a. Informant's Name/Retationship (7 Mya Seery (niece						Rural Route Numbe , Maryland		70wn, State, 2 921	Zip Code)
Baltimore,	Pages 1 a nent of He int: If item iry or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		ceme	River	Cemete:	ry   na)	2006	Indi	ation - City or an Lak New Y	е,
Balt	permit. Pages 'Department of Himportant: If ite any injury or of once.		21. Signature of Funeral Service Lipen			127	South	Main St	Crouch Function	th Ea		
+19 (m)	Physician /Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. CO1	D		ne mode of dying	g, such as card	liac or respiratory ar	rest,		Approximate Interval Between Onset and Death
25	Examiner	35	Sequentially list conditions,	b. Due to (or as a								
/60,	ate be executed nysicien and he burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	consequenc	e of):						
. Box 68	The law requires that the death certificate ate hes been signed by the attending physicage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetat dea		topic pregnancy her (specify)			23	3d. Date of de Month	ivery Day Year
ds, P.O	w requires that the been signed by t should be detach	þ	9 ☐ Unknown  Part II. Dther significant conditions co	ontributing to death bu	t not resulting	in the under	rlying cause give	on in Part I.		obacco us		o the cause of death?
Records,	The law req ate hes beer page 2 shou	Completed			•						prior to death?	utopsy findings available completion of cause of
Vital	ilcien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe		Death (Check only o			
Division of	Attending Physicien: r death. ector: After this certific. by the funeral director, i	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	nt 2□ER/ y Year) 28t	Time of Injury	28c. Injury Work		g Home S Resident Res			cify)
Divisi	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined		ry - At home, (Specify)	farm, street,	factory, office		28f. Location ( City or Tox		Number or R	ural Route Number,
	To the Hospitel or within 24 hours after To the Funeral Direction completely filled in I	Medical O	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best on niner: On the basis of and manner sta	examination	ige, death oc and/or invest	curred at the time tigation, in my op	e, date and pla pinion, death o	ace, and due to the courred at the time,	cause(s) a date and p	and manner as place, and due	s stated. e to the cause(s)
<b>)</b>	To the comple	Me	29b. Signature and title of certifier	MD			29c. License	number		29d. Date	signed (Mont	h. Day, Year)
	4		30. Name and address of person who	completed cause of de	eath (Item 23	a) (Type, Prin	1 <b>y</b> / 5	) 17 = 11	+		7 - 1	LOU'S
74g	St	ate	31. Date filed (Month, Day, Year) MAY 2 4 2	006 32 Registra	Lu 50 ur's Signature	ns Ho	spice.	, EIK	ton,	V		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Anstare of the ry and roll bearing to the art Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Norman Lieberman May 9, 2006 8:16 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 19/30/1906 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🛣 M 2 🗆 F 99 WOBURN, MA 020-<del>21</del>-0951 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. fnside City Limits 10a, State 10b. County 10c. City, Town or Location r than "netural", or items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No MONTGOMERY MONTGOMERY VILLAGE MARYLAND Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19310 CLUBHOUSE ROAD. #325 20886 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No WWII If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married C Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify þ 3 Widowed 4 Divorced leted 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Compl is marked other than Elementary/Secondary (0-12) Colfege (1-4or 5+) CABINET MAKER CUSTOM FURNITURE 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SAMUEL LIEBERMAN ANNE BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health an Importent: if item 27 is any injury or other trauonce. 21536 QUICK FOX LANE, GAITHERSBURG, MARYLAND 20882 GAIL LIEBERMAN, DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 Durial 2 ☐ Cremation 3 Removal from State WOBURN HEBREW CENTER 05/11/2006 WOBURN, MASSACHUSETTS 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foneral Service Licensee 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARÝLAND 20852 Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finaf disease or condition resulting in death) **Physician** acut minutes /Medical Due to (or as a consequence of) Examiner Sequentiafly fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical 23c. ff yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown should should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed: this certificate 1 Yes 2 No 2 No To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA : After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce D033887

State Registrar 31. Date filed (Month, Day, Year) 32 Registrar's Signature 2006 History.

DR. ORLEE PANITCH, 9901 MEDICAL CENTER DRIVE, ROCKVILLE, MARYLAND

MAY 19, 2006

20850

of person who completed cause of death (Item 23a) (Type, Print)

06-03331 Luell Mae Lewis

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 17839

	Registrar	Certificate (	Death	Reg.	No.							
Physician/ Medical Examine				May 17, 200								
	4a. Facility Name (if not institution, give street and numb Regina Drive and Georgia Avenue	er)	4b. City, Town, or Location of Dea Silver Spring	ath	4c. County of Death  Montgomery							
Funeral Director	5. Social Security Number 6. Sex 7. 476-32-4011 1 M 2 🔀 F	Age (In yrs. last birthday) $74$ Y	If Under 1 Year If Under 24H Months Days Hours N	Irs. 8. Date of Birth(I	MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Minnesot							
th the Maryland  23a or 28a-f show any notified at once. al Director	Usual Residence of Decedent  10a. State	10c. City, Town or Loc Silver Sp		10g.	10d. Inside City Limits 1 Yes 2 X No Citizen of What Country?							
s after death with the haral", or items 23a or niner must be notified by Funeral Dir	1510 Interlachen Drive, A  11. Marital Status 1 Never Married 2 Married 2 Married 1 Yes 3 Widowed 4 Divorced or Dates: 15. Decedent's Education (Specify only highest grade	ent Ever in U.S. 13. V es? If 2 No	20906  Vas Decedent of Hispanic Origin? ( Yes, specify Cuban, Mexican, Puel  Yes 2 X No specify:  ent's Usual Occupation (Give kind of	rto Rican, etc.)	USA  14. Race - American Indian, Black, White, etc.  Specify White  Sb. Kind of Business/Industry							
5-0036 led within 72 hours Hygiene. other than "natur. the Medical Exami Completed t	Elementary/Secondary (0-12) College (1-4	or 5+) during	most of working life. DO NOT use r	etired)	Medical							
De fi	Anno Rodewald		Annie	me (First, Middle, Mai Buss								
ore, MD 21 ss 1 and 2 should of Health and Ms If item 27 is ma her traumatic en	19a Informant's Name/Relationship (Type, Print)  Tammy A. Kistler/ Daughte	r 431		atonsville	, Maryland 21228							
<b>2</b> 8 5 5 7	20a Method of Disposition  1 Burial 2 X Cremation 3 Removal from  4 Donation 5 Other Specify:	State Crematory or Metropol	itan Crematory	May 22, 2006 A	Oc. Location - City or Town, State							
- 7	21. Signature of Funeral Service Licensee  23a. Part I. Enter the disease, or complications that caus	5		Lvd, W, Si	lver Spring, MD 2090							
Physician /Medical Examiner	failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Due to (or as a consequence of):											
a. A	Sequentially list conditions, if any, leading to immediate Due to (or as a coloruse. Enter Underlying Cause	ensequence of):										
ccuted and transit al Examiner	(Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a co	insequence of):										
sian a	UNPENDED AMENDED											
D. Box 68760, the death certificate by the attending physicached for use as the burnerly Physician/Mec	23b. Was decedent pregnant in the	t at time of death 5	Fetal death 3 Ectopic preg	inancy	23d. Date of delivery  Month Day Year							
ords, P.O. Box 6 w requires that the death ce s been signed by the attend should be detached for use		eath but not resulting in the	e underlying cause given in Part I.	,	cco use contribute to the cause of death?  2 No 3 Probably 4 Unknown							
2 la la C	24a. Was an autopsy findings prior to completion of codeath?  1 V Yes 2 No 1 V Yes 2											
Vital Reystician: The his certificate director, page	25. Was case referred to medical		26.Place of Death (Che	ck only one)								
Vit hysica this o	examiner?  1 V Yes 2 No Hospital: 1 Inp	atient 2 ER/Outpatie	ent 3 DOA Other Nur	sing Home 5 Re	sidence 6 🗸 Other. Scene							
on of ending Pheath. or: After the funeral	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	Injury 28b. Time of 28b. Time o	f Injury 28c. Injury at Work?  1 Yes 2 V No	28d. Describe how Driver auto au								
Division of Vospital or Attending Photons after death, uneral Director: After ty filled in by the funeral Certification: T	3 Suicide 6 Could not be 28e. Place of	of Injury - At home, farm, st Major Road / Highwa	reet, factory, office building, etc.	or Town, State	eet and Number or Rural Route Number, City e) and Georgia Avenue, Silver Spring							
To the Hospital Youthin 24 hours To the Funeral completely filler	29a. Certifier 1 Certifying Physician: To the best of one) 2 Medical Examiner: On the basis of and manner state	examination and/or investig										
	29b. Signature and title of certifier	/>	29c. License number O.C.M.E.	1.	9d Date signed (Month, Day, Year) May 18, 2006							
	30. Name and address of person who c impleted cause Theodore King MD. Assistant Medica		Penn Street, Baltimore, MD	21201								
State Registra	MIAN G A LUUD MAN	strar's Signature	We .									

			For State	State of			artment	of H	ealth a		•	giene	2006	17810
			Registrar			Cel	rtificate	OT L	Jeain —	1.2	Date of De	Reg. No.	. 0 0 0	3. Time of Death
	Physicia /Medic	an	1. Decedent's Name (First, Middle Emma M. Lehner	o, Last)							Month 15-11-	Dav	Year	5:05 p M
}	Examin		4a. Facility Name (If not institution 1626 Martha Ter		ber)		4b. City, T Rock		Location o	of Death			County of Death ntgomery	
	Funeral Director		5. Social Security Number 261–36–1872	6. Sex 7 1 □ M 2 ☑ F	. Age (In yrs. 93	last birthday) Yrs.	If Under Months	1 Year Days	If Under	Min.	Date of Bird (Month, Da rch,	th		elace (State or Foreign etry) tria
	yland Now		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation	<del>.</del>					1	0d. Inside City Limits
	the Man 28a-f sh totilied	Funerai Director	Maryland Montg	omery	Roc	kville	10f. Zip	Code				10g, Citiz	zen of What Cour	XXYes 2 □ No
	with Ba or		1626 Martha Ter	race			208				1		ed State	•
	ns 23	era	11, Marital Status	12. Was Deced	lent Ever in U	.S. 13.			spanic Ori	gin? (Specif	y Yes or No can, etc.)		14. Race - Americ	an Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, If e.M. dict! Examiner must be mutilied at once.		1 ☐ Never Married 2 ☐ Marr	ied 1 ☐ Yes 2 If Yes, Give Year or Da	X No		lfYes,spec 1 ☐ Yes 2				can, etc.)		Black, White, Specify: Whi	
Baltimore, Maryland 21215-0036	"natura	Completed by	15. Deceden (Specify only highe			16a. Deced	dent's Usua kind of wor DO NOT us	i Occupa k done d	ition u <i>ring</i> mos	t of working		16b. Kir	nd of Business/In	dustry
12	withir ene. than	dmc	Elementary/Secondary (0-12)	College (1-	4or 5+)	Execu						Hote	-1	
Q	filed Hygi othar ant,	Be C	17. Father's Name (First, Middle,	Last)		1					First, Middle,			
ylan	ould be Mental arkad a	To B	Alfred Lebel							Woehr				
Mar	nd 2 shoulth and 27 is m		19a. Informant's Name/Relations Vivien Larranag				9						r Town, State, Zip ) 20852	Code)
lore,	iges 1 au of the		20a. Method of Disposition 1  Burial 2 XCremation			Place of Dispo				Date			cation - City or To	
Ħ	artmer ortant injury		*4 ☐ Donation 5 ☐ Other (S		1 /	t Linc							twood, I	שט Rockville
Ba	Dep Impi		I Can Jun	- Usch-	Moly					, MD			,	
	Physician /Medical Examiner		23a. Part1. Enter the disedse, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a Athero	ch line. sclero or as a consec	tic He, luence of):				cardiac or r	espiratory a	rrest,		Approximate Interval Between Onset and Death
68760,	icate be executed physician and s the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Degen		e Arth	ritis							
.O. Box	that the death certificate ed by the attending phys detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ※XXNo 9 ☐ Unknown		th 2 ☐ Feta int at time of o	al death 3	⊒Ectopic pro ☐ Other (sp					2	23d. Date of delive Month	ery Day Year
<u>α</u>	quires that n signed b	by	Part II. Other significant conditi	ons contributing to de	ath but not res	sulting in the u	inderlying ca	ause give	en in Part I		23e. Did t		_	ne cause of death? pably 4 []Unknown
Il Records,	The law requires that the sate has been signed by the page 2 should be detache	Completed								-	24a. Was autop perfo	psy ormed?	24b. Were auto prior to co death? 1 \( \subseteq \text{Yes}	psy findings available mpletion of cause ol 2□ No
Vital	ysician: The is certificate director, pag	Be	25. Was case referred to medica examiner?	Lionnital:				Othe			Check only o			
of	Phys this al diu	1°	1 ☐ Yes 2 🛣 No  27. Manner of Death	1 🗀 Ir		ER/Outpatier 28b. Time o		/A	4 🗀 140		d. Døscribe		Other (Specif	(y)
u	ding Funel	ion	1 X Natural 5 ☐ Pendi		, Day Year)	Injury	M	8c. Injury Work	ດ?ົ່ ∕es 2 🗆		a. Doddingo	now injury	y occurred	
Division	or Attending after death. Diractor: After in by the fune	Certification:	2 Accident Investi 3 Suicide 6 Could 4 Homicide determ		of Injury - At h g, etc. (Speci	ome, farm, sti fy)	reet, lactory	, office		28	Location ( City or To		d Number or Rura )	il Route Number,
	Hospital 4 hours Funaral ely filled	Medical Ce	29a. Certifier 14 Certifyii (Check only one)	ng Physician: To the Examiner: On the ba and mann	sis of examina	owledge, deat ation and/or in	h occurred evestigation	at the tim	ie, date ar pinion, dea	nd place, and th occurred	d due to the at the time,	cause(s) date and	and manner as s place, and due to	tated. the cause(s)
	To tha within 2 To tha complet	Me	29b. Signature and title of certifie	or 1	0		200	License	number			29d. Date	e signed (Month,	Day, Year)
)	1		<b>&gt;</b> ( )	yna	4	/		3691			5	/17/	2006	
			30. Name and address of person Ajay Reddy, MD	6320 Demo	racy I	Rlvd	Rethe	eda	MD	20817				
	Sta Regist		31. Date liled (Month, Day, Year,	2 2008	gistrar's Sign		Saraka.	, sua,	, <i>L</i> III .	2001/				
	riegist	rui	III I - D		Paralle Andrew	- /								

			_ For	ricase		f Marylar	nd / Depa	artmer	t of H	ealth a				_	1781	-
			- State Ragistrar				Ce	rtifical	e of L	Death			Reg. No.	- 0 0 0	1707	1
	Physicia	an	Decedent's Name (     William I			th					1.	. Date of Dea Month 3.y	Day	2006	3. Time of Death 12:47 A	Л
	/Medic Examin		4a. Facility Name (If n					4b. City	Town, or	Location o	f Death		4c.	County of Deat	h	
			Suburban		1			-	theso		0.411			ntgomer		
4	Funeral Director		5. Social Security Num 406-36-140	66	ex XIM 2□F	7. Age (In yrs. 75	. last birthday) Yrs.	Months Months	Days	If Under 2 Hours	Min.	Date of Birtle (Month, Day			hplace (State or Foreig nintry) Lucky	n —
	and w		Usual Residence of D 10a. State 1	lob. County		10c. C	ity, Town or Lo	ocation							10d. Inside City Limits	s
	e Maryl Ba-f sho	Director		Montgome	ry		Rock								1¶∑Yes 2□Ne	0
	with th	Dire	10e. Street and Numb					10f. Zi	Code	- 0			-	en of What Co	,	
	s 23	era	15305 Bass	swood Co		edent Ever in t	IS 13	Was Dece	2085		nin? (Speci	fv Yes or No-		ted Sta		
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show entry injury or other traumatic event, I're Medical Examination and page.	Completed by Funeral	11. Marital Status  1 Never Married  3 Widowed 4		Armed Fo		58-	If Yes, spe		n, Mexican Specify:	, Puerto Ri	fy Yes or No- can, etc.)		Black, Whit	e, etc.	
Õ	72 hor	ted	(Specify	5. Decedent's Ed only highest gra	lucation		16a, Dece	dent's Usu	al Occupa	ation	t of working	,	16b. Kir	nd of Business	Industry	
21	vithin 7	mple	Elementary/Second		College (	1-4or 5+)				during most ()			Pub1	ic Heal	.th	
2	Hygier ther ther ther ther	S	17. Father's Name (Fi	irst. Middle. Last)	5+		Phy	ysici	an	18. Mothe	r's Name (	First, Middle,	Maiden	Sumame)		
lan	ld be ental ked o	To Be	Bishop Her	nninger	McBeath	1				Annie	e DeJa	arnate	Eng	lish		
Baltimore, Maryland 21215-0036	d 2 shouth and M 7 is mar traumat		19a. Informant's Nam					•		and Numbe	or or Rural I	Route Numbe	r, City or	Town, State, 2		
re, l	Heali Heali Hem 2		Shirley N. 20a. Method of Dispos	sition		20b.	Place of Dispo				Da	te		cation - City or		
timo	ment o		1 ☐ Burial 212 4 ☐ Donation 5	Other (Specify	1)	State	tional	Crem	atory	7	May 19	06	Fal.	ls Chur	ch, VA	
Ball	permit Depart Import eny in		21. Signature of Fuffe	Wm &	and	/	5.1	130 W	iscon	nsin A	Ave. 1	WW Was	hing	's Sons ton, DC		
1	Physician		23a. Part1. Egler the shock or heart Immediate Cause (Fi disease or condition	failure. List only	one cause on e	caused the dea each line. cardial				g, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death 1 Hour	
18.	/Medical Examiner		resulting in death)			(or as a conse croscle		Coron	ary A	Artery	y Dis	ease			10 Years	
6.3	outed ansit	Examiner	Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or in that initiated events	ditions, nediate ying jury	Due to	(or as a conse	quence of):									
,092	ate be executed nysician and he burial-transit	cal	resulting in death) La	st	Due to	(or as a conse	quence of):							-		
68	rtifica ng ph as th	Medi	tF FEMALE:													
.O. Box	it the death certificate by the attending physic tached for use as the b	Physician/Medi	23b. Was decedent print the past 12 m 1 Yes 2 1 9 Unknown	onths?		ointh 2 ☐ Fet nant at time of	aldeath 3[	□Ectopic p □ Other (s					2	3d. Date of de Month	ivery Day Year	
<u>a</u>		by Ph	Part II. Other signific	ant conditions o	-		sulting in the u	underlying	cause givi	en in Part I.					the cause of death?	
ord	w requir been si should I	eted	Diabetes	2 HETTIC	us Type					-		-			obably 4 Unknow	
Vital Records,	The la ate has page 2	Completed										24a. Was autop perfo 1 Tyes		prior to death?	Itopsy findings available completion of cause of 2 No	Θ
/ita	sician: certific rector,	Be (	25. Was case referre examiner?	d to medical							of Death (	Check only o	ne)			
ō	ng Phys fter this ineral di	on: To	1XXYes 2 □ N  27. Manner of Death  1XX Natural	5 ☐ Pending	28a. Date	Inpatient 2 of Injury (th, Day Year)	ER/Outpatie 28b. Time of Injury	of	28c. Injun Wor	y at k?	28	e 5 Resid d. Describe h	-	Other (Spe	city)	
Division	To the Hospital or Attending within 24 hours after death. To the Funaral Director: After completely filled in by the fune	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could not b determined	e 28e. Place	e of Injury - At ling, etc. (Spec	home, farm, st	M treet, facto		Yes 2 □ I		of Location (S City or Tox			ural Route Number,	
	lospital t hours a unaral C	edicai Ce	(Check only 2	Certifying Ph	ysician: To the	e best of my kr	nowledge, dea	th occurre	d at the tin	ne, date an pinion, dea	d place, an	d due to the	cause(s)	and manner as	s stated.	
	To the P within 24 To the F complete	Med	one) 29b. Signature and ti			ner stated.			c. Licens					e signed (Mont		
	10		+ Car	la ()	Hanne	the	1=11		P	399	166		May	16, 20	06	
	10		30. Name and address	ammet MD	1835 U				226	Hyatt	svill	e, MD	2078	33		
	Sta Regist		31. Date filed (Month	Y 2 2 20	06	Registrar's Sign	nature	uli								

Registrar DHMH 17 Rev 1/2001

State

31. Date fied (Month, Day, Year,

26 2006

parke)

32. Registrar's Signature

			1 - For State Registrar	State	of Maryla	nd / Depa <i>Cei</i>	artmer <i>rtificat</i>	nt of H	ealth a Death	ınd M	ental I		ene [	06	17843
	*		1. Decedent's Name (First, Midd.	le, Last)							2. Date o	f Death	Day	V	3. Time of Death
	Physici /Medic		Paulo Fernando	Vilar Mor	nteiro 1	Mendes					May .	19,	2006	Year	11:00AM
	Examin		4a. Facility Name (If not institutio	n, give street and n	umber)		4b. City.	Town, or	Location of	f Death			4c. County	y of Death	
			4412 Sangamore	Road			Beth	iesda					Montg	gomer	У
Pr SECTO	Funeral Director		5. Social Security Number 441–46–7268	6. Sex 1X M 2 ☐ F		s. last birthday) 69 Yrs.	If Unde Months	Days	If Under 2 Hours	Min.	8. Date o (Month	, Day, Y	ear) 1936	9. Birthp Coun Braz	
	P _		Usual Residence of Decedent		1										
	arylar show	_	10a. State 10b. County		10c. C	City, Town or Lo	cation							1	Od. Inside City Limits
	8a-f	cto		gomery	Bet	thesda									1 ☐ Yes 2X No
	with th	Dire	10e. Street and Number					Code					. Citizen of	What Coun	itry?
	death with the Maryland me 23a or 28a-f show r milet be rotified at	Funeral Director	4412 Sangamore			110	208		. 0.	. 0.40	7 14		razil		
	itam itam	nue	11. Maritaf Status 1 ☐ Never Married 2 🛣 Mar	Armed F			was Dece f Yes, spe	cify Cubai	spanic Orig n, Mexican,	in? (Spe , Puerto F	Rican, etc.	r No- )		ce - Americ ck, White,	
3	hours after turel', or ite	by F	3 ☐ Widowed 4 ☐ Divorced	ff Yes G	2 <b>X</b> No aive Dates:		1 🗆 Yes	2 <b>X</b> No	Specify:				Specif	y: Whit	
9500-91212	be filed within 72 hours after death with the Marylan Hygiene.  d other than "natural", or itama 23a or 28a-f show event, it a Madical Examinar must be notified at	ed		nt's Education		16a. Deced	dent's Usu	al Occupa	ation			16	b. Kind of B		
ე. ე.	within 72 ene. then nei te Medic	Completed		st grade completed	(1-4or 5+)	(Give	kind of wo	ork done d se retired	luring most )	of workir	ng				,
77	d with	E	Elementary/Secondary (0-12)		5+	Chemi	cal E	ngin	eer			P1	harmad	ceutio	cal Co,
	e filed within al Hygiene. I other then vent, II c. Me	ВеС	17. Father's Name (First, Middle,	Last)					18. Mother	r's Name	(First, Mic	ddie, Ma	iden Sumar	me)	
	2 should be fi and Mental H ie marked of raumatic ever	To	Paulo Monteiro  19a. Informant's Name/Relations			10h Mailie							e Arag		
	es 1 and 2 should b of Health and Ment I Itam 27 ie markec r other traumatic e		Paula Mendes Ha		ghter		-						D 2081		C00e)
altimore,	permit. Pages 1 and Department of He importent; if Item any injury or oth angle.		20a. Method of Disposition  1   Burial 2   Cremation		n State	Place of Dispo	-				ate		c. Location		
	nt. Printme	- 1	4 Donation 5 Other (S		GI	hesapeal									Maryland
g	Depa Depa impo any i		21. Signature di Punerai Sovice	PILI	11								e P.C		
A. 16.	4		23a. Part 1. Enter the disease, o	r complications that		1251 Be	ever1	y L.	Heck	rott	e, P.	A. (	Clarks	sville	Approximate
			shock, or heart failure. List fmmediate Cause (Final	only one cause on	each line.	ain. Do not ont	01 (110 1110)	or dynng	g, 3deir d3 e	sardiac (i	respirato	iy airest	•		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		MEWTI										
30°.	Examiner		,	Due to	o (or as a conse	equence of):									
	- A	er	Sequentially list conditions, if any, leading to immediate	b. — Due to	o (or as a conse	equence of):								-	
	ansit	Examiner	Cause (Disease or injury	<											
,	be executed icien and burial-transit	Exa	that initiated events resulting in death) Last	c. Due to	o (or as a conse	equence of):								-	
8/60	icate be executed physicien and s the burial-transit	dical		d											
Q	certificate nding phys use as the	40													
X OR	h cer andin use	lan/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pregr		Ectopic p						23d. Da	te of delive	ry
	deat	O	in the past 12 months? 1 □ Yes 2 □ No	4☐Preg	gnant at time of		Other (sp						Mo	onth	Day Year
л Э	at the by the tache	Physi	9 Unknown	9□ Unkr	nown										
	<b>— Ф</b> ○	by F	Part ff. Other significant conditi	ons contributing to	death but not re	sulting in the ur	nderlying o	ause give	n in Part I.		23e. E	id tobac	co use cont	tribute Io th	e cause of death?
D	requires een sign nould be		DIVELLED	MERLITUS	TPS	2, 6	mou	حد			1	☐ Yes	2 XNo	3 Proba	ably 4 □Unknown
ψ Ο	2 2 8	ompleted									24a. V		24b.	Were autop	psy findings available inpletion of cause of
	0 5 0	E O									p 1□ Ye	utopsy erformed s 2	d? INO	death? 1 \sum Yes	
VII	ysicien: Th is certificate director, pag	BeC	25. Was case referred to medica	1					26. Place	of Death					
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	ng Pl		27. Manner of Death 1 ★Natural 5 □ Pendir	28a. Date (Mo)	of Injury nth, Day Year)	28b. Time of Injury	2	28c. Injury Work	at ?	2	8d. Descr	be how	injury occur	red	
0	Attending r death. ector: Afte by the fune	atle	2 ☐ Accident investi	gation			М		′es 2□N	lo					
DIVISION	or Att	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Prac	e of Injury - At ding, etc. (Spec	home, farm, stri cify)	eet, factor	y, office		2	8f. Locatio City or	n (Stree Town, S	et and Numb State)	er or Rurai	Route Number,
_	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical Co	(Check only [2] Madical	ng Physician: To th Examiner: On the l	ne best of my kr	nowledge, death	occurred	at the time	e, date and	place, a	nd due to	the caus	se(s) and ma	anner as sta	ated.
	thin 2- the F mplets	Medi	one) 29b. Signature and title of celtifie	and mai	nner stated.			c. License					Date signe		
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0)6	<i>&gt;</i>		30. Name and address of person Jerold M. Share			em 23a)(Type. ∀ Mexico		NU	Wacl	hino	ton.	D.C	2001	6	
	Sta	te	31. Date filed (Month, Day, Year)	32.1	Raistrar's Sign	nature			, 11461	8		2.0	. 2001		
	Registr	-		3 2006	Colve	1. 1	mark								

06-03223

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State of Maryland / Department of Health and Mental Hygiene Arnaldo Moran 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month May 13, 2006 0430 hrs Medical Examiner Arnaldo Moran 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore University of Maryland Medical Center If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Davs Hours Min Months Director Country) Guatemala 03/10/1964 1 X M 2 F 42 Yrs none Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a State 10h County 1 Yes 2 No 28a-f show MD LAUREL items 23a or 28a-f shoust be notified at once. hours after death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20708 9121 Elaine Ct. **GUATEMALA** Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black 11 Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 1 X Never Married 2 Married Yes 2X No 0. 1 X Yes 2 No specify: Guatemalan Specify: Hispanic If Yes. Give Year 3 Widowed Divorced Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygene ant: If item 27 is marked other than "natural", and or other tranmaitic event, the Medical Examiner. ð 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 BATES TRASH REMOVAL. Trash Removal 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Francisca Jimenez Ramirez. Esteban Moran Flores Be 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ MD 20912 20c. Location - City or Town, State 28 Lee Ave. #6 Tacoma Park. Alex Moran (Brother) 20b. Place of Disposition (Name of cemetery crematory or other place) 1 K Burial 2 Cremation 3 Removal from State Asuncion Mita, Jutiapa permit. Pages
Department or
Important: Cementery: Estanzuela 05/25/2006 Donation 5 Other Specify Guatemala. 22. Name and Address of Facility Santa Cruz Servicios Funerarios. 21. Signature of Fune 600 Kennedy St. NW. Washington, DC. 100 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated Due to (or as a consequence of): events resulting in death) Last pue Physician/Medical X AMENDED item#28b,28f,perME,G856,6/23/06 TT rending physician a UNPENDED Division of Vital Records, P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of To the Hospital or Attending Physician: The law death? performed? this certificate page ✓ Yes 2 No ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Other<sub>4</sub> examiner? Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 Other 1 🗸 Yes 2 No 28a. Date of Injury 28c. Injury at Work? After 28d Describe how injury occurred 27. Manner of Death 28b Time of Injury Certification: May 12, 2006 Pedestrian struck by vehicle 1 Natural 1 ✓ Yes 2 No <del>7/2</del>4"AM 5 Pending after death Director: d in by the 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number of Rural Route Number, City or Town, State) Sunrise Beach Rd & 3 Could not be Suicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cadse(s) and manner as s Medical Examiner: On the basis of examination and/or investigation in my opinion. thin 24 hours a Homicide Crownsville, MD 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 9 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) atur 29b O.C.M.E May 14, 2006 id address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. Assistant Medical Examiner 1 Date filed (Month, Day, Year) 32. Registrar's Signature 2 2 2006 Registra **ORIGINAL** 

State of Maryland / Department of Health and Mental Hygier (2) 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY 28, **Physician** JOHN В. MATEER Year 2006 7:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WILLIAMSPORT HOMEWOOD AT WILLIAMSPORT WASHINGTON 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 2/5/1917 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 094-24-0721 1 M 2 ☐ F 92 PERNSYLVANIA Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or items 23s or 28s-f show the Mudical Examinar must be notified at WV BERKELEY HEDGESVILLE 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25427 1148 WINTER CAMP TRAIL USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Amed Forces? 1 ဤ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE δ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry WESTINGHOUSE Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ont: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) CONTRACTS MANAGER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EDNA FARBAUGH BLANDON VINCENT MATEER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1148 WINTER CAMP TRAIL, HEDGESVILLE, WV 25427 19a. Informant's Name/Relationship (Type, Print) GLADYS ANNETTE MATEER/SPOUSE 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State SMITHSBURG CREMATORY MAY 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. SMITHSBURG, MD 4 ☐ Donation 5 ☐ Other (Specify) 31. 2006 22. Name and Address of Facility BROWN EUNERAL HOME P.O. BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 21. Signature of Funeral Service Licenses Charles M. Brown 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death preumonia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): igned by the attending physicien and be detached for use as the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 25 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Parkinson's disease 1 Yes 1 ☐ Yes 2 ☐ No ₽ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, f. 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: Surring Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🚱 No 3 DOA 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certi 046940 person who completed cause of death (Item 23a) (Type, Print) 13434 Pennsylvania Avenue Hagerston MO 31742 286 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Lawrence L. Muns	1	- For State	Stat	e of Maryla		oartment o	f Health and f Death	d Mental H	-,	Reg. No. 20	06 1784
Physician Medical Examine	7	Registrar 1. Decedent's Name LAWRENCE							2. Date of De Month May 24,	eath Day Year	3. Time of Death 1145 hrs
		4a. Facility Name (if 18500 Living		give street and nu	umber)		4b. City, Town, or L Accokeek	Location of Death	1	4c. County of Department of Country of Count	
Funeral Director	:	5. Social Security N 217–64–76		Sex M 2 F	7. Age (In yrs <b>51</b>	. last birthday) Yrs	If Under 1 Year  Months Days	If Under 24Hrs Hours Mir	AUGUS	T 26,1954	Birthplace (State or or oreign WASHINGION, Country)
any		Usual Residence of 10a. State				ty, Town or Local	ion	· · · · · ·			10d Inside City Limits
yland -f show once.	<u> </u>	MARYLAND  10e. Street and Nur	PRINCE C	EEORGES	AO	OOKEEK	10f. Zip Code			10g. Citizen of What	1 X Yes 2 No
3a or 28a-f sh		18500 LIVIN		ND (II)			20607			UNITED STAT	
Baltimore, MD 21215-0036  permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyggene Important: If item 27 is marked other than "natural", or items 23a or 28a-15 show any injury or other traumatic event, the Medical Examiner must be notified at once.  To De Computed by Europel Director	by runera	<ul> <li>11. Marital Status</li> <li>1 X Never Marrie</li> <li>3 Widowed</li> </ul>		0	2 <b>A</b> No		is Decedent of Hisp es, specify Cuban, Yes 2 X No	Mexican, Puerto		White, e	American Indian, Black, etc.
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MD 21 d 2 should th and Me n 27 is ma aumatic ev	2	19a. Informant's Na LA SHANNAN					Address (Street <b>E DRIVE, 11</b>			umber, City or Town, s	State, Zip Code)
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Baltimore, permit Pages I ar Department of Her Important: If ite	1	4 Donation 5		ify:	onser S	T. CHARLES			-	GLYMONT, N	
m aa a≡ s Physician	-	LADIA C. TI	HORNION J		M00583	th. Do not enter t	9 LIVINGST	N ROAD, '	NDIÂN HE	AD, MARYLANI	20640 Approximate Interval
/Medical Examiner	liner	Immediate Cause (I or condition resulting Sequentially list configure any, leading to improve cause. Enter Under	ng in death)  nditions,  nmediate  rlying Cause	Due to (or as a			e				Between Onset and Death
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of Vital Records,  ng Physician: The law require the this certificate has been si nertla firector, page 2 should be	Completed								24a. Was auto perf 1 ✓ Yes	opsy prio ormed? dea	re autopsy findings available r to completion of cause of th?  Yes 2 No
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- 3 - 3	Ž	29b Signature and	title of certifier	01	1) 1		29c License			29d. Date signed May 25, 2006	(Month, Day, Year)
		30. Name and addr	ess of person w	ho completed cau	se of death (Ite	em 23a)					
di.			nica-Pollak I	32. P	ant Medica	l Examiner	111 Penn Str	reet, Baltimo	re, MD 2120	01	
Star Registra	te ar	31. Date filed (Mon	MAY 3 1	2006	Celve	1. 6	will -			<del></del>	

			For State Registrar	State of Mar	yland / Dep		lealth and	Mental Hy	•	17847
<sub>2</sub> /N	ysicia ledic amine	ai .	1. Decedent's Name (First, Middle, L.  Norman Cop  4a. Facility Name (If not institution, gi	ve street and number)	nch	4b. City, Town, o	Location of De	2. Date of Dea Month MOUY ath	Day Yea 200	6 2250 PM
Fund Direct			Ciledia	Spital Cen Sex 7. Age (	HCF (In yrs. last birthday 78 Yrs.	UNEST If Under 1 Year Months Days	If Under 24 Hi Hours Mi	rs. 8. Date of Birtl	Ken-	irthplace (State or Foreign Country) MD
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3a or 2	M De Ca	ai Dire	338 ROUNDTOP ROA	D		10f. Zip Code 21620	)		10g. Citizen of What USA	Country?
OUSO hours after death ural', or iteme 2	EXAMELEC IN	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates:	er in U.S. 13	Was Decedent of H If Yes, specify Cuba  1 ☐ Yes 2 No	ispanic Origin? an, Mexican, Pur Specify:	(Specify Yes or No- erto Rican, etc.)		nerican Indian, nite, etc. WHITE
ITE, INIZITYIZITICA Z I Z I D-UUJO s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other then "natural", or Iteme 23s or 28a-1 show	the Mudical	Completed	15. Decedent's 8 (Specify only highest gi	Education rade completed) College (1-4or 5+)	16a. Dec (Giv life. TRU(	edent's Usual Occup e kind of work done DO NOT use retired K DRIVER	ation during most of w	vorking	16b. Kind of Busines	
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Mar nd 2 sho lith and 27 io m	r traum		19a. Informant's Name/Relationship CONSTANCE MENCH/						or, City or Town, State NN , MD 216	
baltimore, permit. Pages 1 an Depertment of Heal Important: if item 2	ry or othe		20a. Method of Disposition  1    ↑ Burial 2 □ Cremation 3    4 □ Donation 5 □ Other (Spec		20b. Place of Disp cemetery, cre MARYLANI	oosition (Name of ematory or other place)  VETERAN	S 05/	Date 26/2006	20c. Location - City HURLOCK,	
Daltimo permit. Pages Depertment of	eny injury once.		21. Signature of Funeral Service Lice	Insee Telfert	(2)	22. Name and Addres FELLOWS H L30 SPEER	ss of Facility IELFENBE ROAD C	IN AND NE	EWNAM FUNR	EAL HOME, P.A
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COIGS, P.O. BOX 08/00, wrequires that the death certificate be executed been signed by the attending physician and	ched for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir 9□Unknown	Fetal death 3	□Ectopic pregnancy			23d. Date of o	elivery Day Year
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To the To the	comple	Me	29b Signature and time of certifier			29c. Licens	_		29d. Date signed (Mo	
4/ Sla	ti	(	30. Name and address of person who	o completed cause of dea	th (Item 23a) (Type	0, Print)	605)	<b>y</b>	5-22	-Ole
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Re	Star gistr	200	31. Date filed (Month, Day, Year)  MAY 2 2	32. Registar	s signature	Sough D				

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician 19, 10:45P<sup>M</sup> ALEXANDER STEPHEN NAGY MAY 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SEVERNA PARK
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. HOUSEHOLD OF ANGELS ASSISTED LIVING ANNE ARUNDEL 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 2□ F Yrs. Director <u> 288 16 8558</u> 83 MAY 25,1922 OHIO Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2 ☐ No Director MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? r then "naturel", or iteme 23s or the Medical Examiner must be 802 COXSWAIN WAY #303 21401 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 Syes 2 No If Yes, Give Year or Dates: 1942-45 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MECHANICAL ENGINEER ELECTRONICS 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be innent of Health and Mental Innert: If Item 27 is marked o ဥ ALEXANDER ELIZABETH KATONA NAGY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET NAGY (WIFE) 802 COXSWAIN WAY #303 ANNAPOLIS, MD. 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Importent: if it eny injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) MARYLAND VETERANS CEM05-23-06 CROWNSVILLE MD. 22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 2973 SOLOMONS ISLAND ROAD EDGEWATER MD. 21037 2973 SOLOMONS ISLAND ROAD E

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Kinsons Disease Immediate Cause (Final disease or condition **Physician** 5 years resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine ettending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) ed by the e 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 2U No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificete has t lirector, page 2 s autopsy performed? 1□ Yes 2√ No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) ASSISTED ို 1 Yes 2 No 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: LIVING 5 Pending 1 XNatural investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29b. Signature and of certifie 29d. Date signed (Month, Day, Year) 29c. License number 00 29571 MAY 20,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEFENSE HIGHWAY SUITE E CROFTON, MD. 21114 PAUL B. BEREZ M.D. 2225 31. Date filed (Month, Day, Year) 2 2 2006 32. Registrar's Signature State Registrar

		For State Registrar	State of Maryla	•		of Death		R	eg. No.	U U 6	17849
Physicia		Decedent's Name (First, Middle, Last					2	2. Date of Deat Month	Day	Year	3. Time of Death
/Medica	al -	Robert Wayne  4a. Facility Name (If not institution, give		·	4h City To	wn, or Location of	of Death	May	18, 20	006 nty of Death	1:23 P M
Examine	er	693 208th Street				asadena	or Death			ne Arı	ındel
Funeral		5. Social Security Number 6. S		s. last birthday)	If Under 1 \		24 Hrs. 8	B. Date of Birth (Month, Day,			place (State or Foreign
Director		214-40-0030	M 2□F 6	4 Yrs.	Moritins	vays Hours	1	Jan. 5,	1942		land
*	-	Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	ocation						10d. Inside City Limits
neillise at	<u> </u>	Maryland Anne Ar	undel	Edgewa	ter						1 ☐ Yes 2 💆 No
or 28a-f ehow a notified at	Lec	10e. Street and Number			10f. Zip Co	ode		1	0g. Citizen o	of What Cou	ntry?
239 C	<u>a</u>	1629 Havre de Gra	ce Drive		2	1037			USA		
9 5	by Funeral Directo	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4X□Divorced	12. Was Decedent Ever in Armed Forces? 132 Yes 2 □ No If Yes, Give Year or Dates: 196		Was Deceden If Yes, specify 1 ☐ Yes 2X	t of Hispanic Orig Cuban, Mexican No Specify:		ify Yes or No- ican, etc.)	В	ace - Americack, White,	etc.
odical Ex		15. Decedent's Ec		16a Dece	dent's Usual C	Occupation			16b. Kind of	Business/In	dustry
Agg .	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed)	(Give	kind of work of DO NOT use i	done during mosi retired)	t of working	9			·
3	E	11th	College (1-4or 5+)	Supe	rvisor				Anne A	Arunde	l County
× ×	To Be	17. Father's Name (First, Middle, Last) Eldridge Paddy				18. Mother		(First, Middle, I Ve	Maiden Sum	ame)	
E I	3	19a. Informant's Name/Relationship (	**			treet and Numbe					
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eny Injury or othe once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	Removal from State	cemetery, cre-	matory or othe	r place)		100	avidso		
nam'.		4 □ Donation 5 □ Other (Specification 21. Signatur Filteral Service Light				al Gdns.		2-00			
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ian		Immediate Cause (Final disease or condition	Liver :	failux A	1						Onset and Death
ical iner		resulting in death)	Due to (or as a cons	equence of):	,			•			Decky
	_	Sequentially list conditions,	b. Netasta  Due to (or as a consi	tie Cl	olonec:	TAR O	GACO	R			YEARS
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the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as a conse	equence of):							
5	cal	(	d								
		IF FEMALE:									
	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg	tal death 3	⊒Ectopic preg					Date of delive Month	ery Day Year
	SICI	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5	Other (speci	<i>fy)</i>	·				
		Part II. Other significant conditions of	ontributing to death but not re	esulting in the u	nderlying caus	se given in Part I.		23e. Did tol	nacco use co	ontribute to t	he cause of death?
	d b							1 🗆 Ye	as 2□No	3 Prot	ably 4 ∐Unknown
	Completed							24a. Was a	n 24t	b. Were auto	ppsy findings available
bage 2	EO							autops perform	ned?	prior to co death? 1 \sum Yes	mpletion of cause of 2□ No
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al direc	2	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2	· · · · · · · · · · · · · · · · · · ·		Other: 4 Nu	rsing Hom	e 5 ☐ Reside	ence 6x2	ther (Specia	Daughter's <sup>(y)</sup> Home
		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		Injury at Work?	i	3d. Describe ho	w injury occ	urred	
1001	cat	2 Accident investigation 3 Suicide 6 Could not b		home form et	M root factory o	1 Yes 2		Rf Location (Cf	reat and Nu	mbor or Pur	al Route Number,
Š	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	cify)	reet, factory, o	тсе	20	City or Town	, State)	moer or mura	ar Houle Number,
		29a. Certifier 1 Cartifying Ph	ysician: To the best of my k	nowledge, deat	h occurred at	the time, date an	nd place, ar	nd due to the ca	ause(s) and	manner as s	stated.
completely filled in by	Medical	one)	and manner stated.	nation and/or in			illi occume				
COU	2	29b. Signature and title of certifier	100			icense number	and a		9d. Date sig		
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Į		30. Name and address of person who						м.D.			
Stat	e.	Johns Hopkins Ur 31. Date filed (Month, Day, Year)	32. Raistrar's Sig		MITIMO	re, MD 2	(1231				
Registra	_	MAY 22	2006	M. A	Shooth 1	į!					

		1 - For State Registrar	State of M	aryland / De		nt of H	lealth a	and N	lental Hy		0.05	17850
Physici	an	1. Decedent's Name (First, M	ordean Peters						2. Date of Dea Month May	ath Pax	2006	3. Time of Death
/Medic	cal	4a. Fecility Name (If not institu			4h Cih	Tour or	Logation	of Dooth	May			11:30Pm
Examin	ner	8012 Max Blol			- 1	Jessu	Location o	or Death			ounty of Death nne Arui	nde1
Funeral		5. Social Security Number		e (In yrs. last birtho	day) If Unde	r 1 Year	If Under		8. Date of Birt			lace (State or Foreign try)
Director		173-03-1117 Usual Residence of Decedent	1 💢 M 2 🗆 F	91 Yr.	s. Months	Days	Hours	Min.	8. Date of Birt (Month, Da) Nov 12	, 191	4	PA PA
faryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or Itams 23a or 28a-f show sumatic event, the Madical Examinating the notified at		10a. State 10b. Cou	•	10c. City, Town o	_						1	Od. Inside City Limits
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d 2 illed Hygin other	Be Co	17. Father's Name (First, Mide	dle, Last)		raciii	HISC	18. Mothe	er's Name	e (First, Middle,			·Ρ
rlan uld be Mental rkad tic ev	To B	Wilbur Gl	enn Peters				Co	ora l	Blanche	Shel	don	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Infinoriant: It flem 27 is marked other than "natural", or Itams 23a or 28a-1 show any Injury or other traumatic event. It was deal Examination or other provided at once.		19a. Informant's Name/Relati	ionship (Type, Print)	19b. N	lailing Address	(Street a	and Numbe	or Aura	il Route Numbe	r, City or T	Town, State, Zip	Code)
and and sealth m 27 har tr		Katherine Pe	ters wife	2 80	012 Max	k Blo	b's I				MD 207	
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Itim it. Pa intmer intant njury		*4 □ Donation 5 □ Othe  21. Signature of Funeral Serv		Cremat	orium	od Addess	a of Equilib			-		PA 17268
Ball permi Depa Impo any Ir			IM Mou	u	50 S.	Bros	id St	. Way	nesboro	o, PA	17268	l Home, Inc
Physician		23a. Part1. Inter the disease shock, or heart failure. Immediate Cause (Final	e, or complications that caused List only one cause on each li	ne.	,							Approximate Interval Between Onset and Death
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Of \Physical direction	2	1 ☐ Yes 2 ☑ No	Hospital:			_	4   1401				Other (Specify)	
On On On On On On On On On On On On On O	ton:	27. Manner of Death 1 ♣ Natural 5 ☐ Per	28a. Date of Inju (Month, Date of Stigation	ry 28b. Tim y Yea <i>r)</i> Inju	e of 2 ry M	8c. Injury Work	at ? ′es 2.⊟N	ì	28d. Describe h	ow injury o	ccurred	
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To th within To th	Me	29b. Signature and title of con	tifier	`	290	. License		11.1+			igned (Month, D	
		1 /	m mi	)			334				1 24,0	6
SH-8		30. Name and address of pers Kenneth Wil	son who completed cause of d liams, MD 11	eath (Item 23a) (Ty) 20 N. Ro	pe Print) lling F	Rd. C	atons	svil]	Le, MD 2	2 <b>122</b> 8		
Sta Registra		31. Date filed (Month, Day, Ye	26 2006 32. Registra	ar's Signature	persas							

			1 - For State Registrar	S	tate of M	1aryland		artment <i>tificate</i>				lental Hyg	giene	06	178	5
			1. Decedent's Name (First, Mid	dle, Last)								2. Date of Dea Month	th Day	Yeer	3. Time of De	ath
	Physic /Medi		Dwight		Willi	am		Peter	s			May		006	2240	M
	Exami		4a. Facility Name (If not institut							Location of	of Death		4c. County	of Death		
			Anne Arundel	Medica 6. Sex		er Age (In yrs. la	and himboland	An If Under	napo	lis If Under	24 Hrs	8. Date of Birth			indel	araian
	Funeral Director		5. Social Security Number  215-62-4656  Usuel Residence of Decedent		2□ F /.A	51	Yrs.	Months	Days	Hours	Min.	(Month, Day	Year) 4, 1954	Wash	place (State or Fo ntry) nington,	DC
	Maryland	tor	10a. State 10b. Cour	<sub>ty</sub> ne Arun	ndel		Town or Lo		****						1 ☐ Yes 2	
	or 28e	Director	10e. Street and Number					10f. Zip	Code				10g. Citizen of \	Vhat Cou	ntry?	
	23a		4887 Anchors	Way					207					USA		
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28e-f show other treumatic event, the Madical Exp. Inservant be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2XXM 3 ☐ Widowed 4 ☐ Divorc	arried	Was Deceden Armed Forces 1 ☐ Yes 2X If Yes, Give Year or Dates	? JNo		Was Deced f Yes, spec 1 ☐ Yes 2				ecify Yes or No- Rican, etc.)	14. Rac Blac Specify	k, White,	can Indian, etc. nite	
21215-0036	ithin 72 ho ne. nan *natur	Completed	(Specify only high Elementary/Secondary (0-12		on <i>ompleted)</i> College (1-4or	r 5+)	(Give life. 1	tent's Usua kind of wor DO NOT us	k done a e retired,	lurina mos	t of work	ing	16b. Kind of B			
Maryland 21	12 should be filled within hand Mental Hygiene. 7 Is marked other than ** freumatic event, Inc. Mar.	Be	12 17. Father's Name (First, Middle Merlin I. Pet				Contr	actor				(First, Middle,	Maiden Suman	lding	5	
Z	should nd Me mark mark	မ	19a. Informant's Name/Relatio		Print)		19b. Mailir	ng Address	(Street a			Il Route Numbe		State, Zip	Code)	
Z	alth a 27 Is or treu		Kathryn L. Pe	ters	(Wife)		4887	Ancho	rs W	lay,	Gale	sville,	MD 207	65		
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 Is any injury or other treu once.		20a. Method of Disposition 1 ☐ Burial 2 【 Crematio 4 ☐ Donation 5 ☐ Other		oval from Stat	e C6	ace of Dispo emetery, cren tro Cr	natory`or ot	her place		-16-	2006	20c. Location -			
Balti	permit. Departm Importe any inju		21. Signature of Funeral Service	DLicensee	•		22		esty	s of Facility Fun	eral	Home, l	P.A.			
	Physician /Medical Examiner		23a. Part1. Enter the disease, shock, or heart failure. LImmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	or complication only one of	ause on each	line.	reumo	er the mode							Approximate Interval Betwee Onset and Dea	in .th
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	`	s a consequ										
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<u>\$</u>	ys dir	70 6	1 ☐ Yes 2 🕱 No	Hos	1 Minpa		ER/Outpatien				rsing Ho	me 5 ☐ Resid	ence 6 🗆 Oth	er (Specif	(y)	
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	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical	(Check only 2 Medic	al Examiner	an: To the bes On the basis and manners	of examinati	wledge, death ion and/or in	vestigation,	in my op	inion, dea	d place, th occurr	and due to the c ed at the time, d	ate and place,	and due to	the cause(s)	
)	To To To Com	2	29b. Signature and title of certi	it with	ich, bl	10		29c.	D'	number 4605	2	inapotis	9d. Date signed 5   16	1	uay, Year)	
			30. Name and address of person	Bech	(tu)			Print)	Parke	nby	a	napolis	, Mo			
	St	ate	31. Date filed (Month, Day, Ye.	ar) I O 200		trar's Signat	erus	*								

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ORIGINAL

			. For	y <b>pe or Print in E</b> State of Marylan	d / Depa	artment of H	ealth and N	_	iene	
			1 - State Registrar		Ce	rtificate of l	Death	Re	g. No. 4 U U	6 17852
	Physici /Medic		1. Decedent's Name <i>(First, Middle, Last)</i> Edwin Randolph	Phillips				2. Date of Death Month May 1	Day 2006	
	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or	Location of Death		4c. County of D	Peath
			Genesis HealthCar	e - the Pine	3	East			Talb	ot
	Funeral Director		213-07-7410	7. Age ( <i>In yr</i> s. 84	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan. 13,	<sup>Year)</sup> 1922 9.	Birthplace (State or Foreign Country) Maryland
	pud *	}	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ncation				10d. Inside City Limits
C	sho	5	MD Dorche		,, , , , , , , , , , , , , , , , , , , ,		bridge			1 Maryes 2 □ No
$\langle$	286-1	Director	10e. Street and Number	Deel		10f. Zip Code	orrage	10	g. Citizen of What	t Country?
5	with se or	₫	410 Edlon Park				1.61.3			
	leath	era		2. Was Decedent Ever in U	S. 13.	Was Decedent of Hi If Yes, specify Cuba	1613 spanic Origin? (Si	pecify Yes or No-	USA 14. Race - A	American Indian,
<i>3</i>	riter	Funeral	1 ☐ Never Married 2 Married	Armed Forces? 1 XYes 2 □ No	i			Rican, etc.)	,	Vhite, etc.
9	el'.o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: WWI	[	1 ☐ Yes 2 🗷 No	Specify:		Specify:	white
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. In marked other then "naturel", or Items 23e or 28e-f show eumetic event, the Medical Examinating to notified at	Completed	15. Decedent's Educ. (Specify only highest grade		(Give	dent's Usual Occupa	luring most of won		6b. Kind of Busine	ess/Industry
2	ithln nen.	np(	Elementary/Secondary (0-12)	College (1-4or 5+)	Ìife.	DO NOT use retired	)		~~~~~ _ L	
2	ted w lygier her ti	S	11			owner	10. Markada Nam	- (Final Ministra	carpet	store
4000	m - 0 2	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, M	ашеп Ѕитатеј	
Ž	d Me d Me nark	၉	Elbert D. Phill  19a. Informant's Name/Relationship (Typ		10b Maili	ng Address (Street a		Brannock		le Zin Code)
Z Z	d 2 s th an 17 le r treur		Dorothy Phillips	wife	1				0.000000	e, zip code)
ည်	1 an Heal tem 2		20a. Method of Disposition	20b. F	lace of Dispo	Edlon Par esition (Name of			21613 20c. Location - City	or Town, State
<u>o</u>	ages ant of it: If i		1 X Burial 2 ☐ Cremation 3 ☐ Re  1 4 ☐ Donation 5 ☐ Other (Specify)	moval from State		matory or other plac er Memoria		5/22/06	Combra d	o MD
Baltimore,	nit. Fartme		21. Signature Funeral Service License			2. Name and Addres				
ñ	permit. Pages 1 and 2 should be Department of Heatils and Menia Importent: If item 27 le marked eny injury or other treumetic av <u>once</u> .	å V	I John John	~		700 Locust				
	Pnysician		23a. Partly Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the deat cause on each line.	n. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq	uence of):	V VILLE				acers
П	Examiner		Sequentially list conditions, b. if any, leading to immediate							
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):					
	be executed ician and burial-transit	xan	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of);					
260	te be executed ysician and e burial-transit	calE								
89	death certificate I attending physi I for use as the b									
Box	h cert endin use	M/U	230. was decedent pregnant	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy			23d. Date of	
P.O. B	The law requires that the death certificate te has been signed by the attending phys age 2 should be detached for use as the	by Physician/Medi	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of d 9☐Unknown		Other (specify)			Month	Day Year
	res that the de signed by the a be detached f	/ Ph	Part II. Other significant conditions cont	ributing to death but not res	ulting in the u	nderlying cause give	in in Part I.	23e. Did toba	acco use contribut	e to the cause of death?
ds	quires n sigr ald be	d b	Atherosyles Hypertene	0575				1 ☐ Yes	s 2,500 3 □	Probably 4 Unknown
00	tw require s been sig should b	olete	Ungertens	יופיה.				24a. Was an	24b. Were	autopsy findings available
Re	nyeiclen: The law nis certificate has I I director, page 2 s	Completed					· · · · · · · · · · · · · · · · · · ·	autopsy perform 1 Yes 2	ed2 death	to completion of cause of n? res 2 \sum No
<u>ta</u>		BeC	25. Was case referred to medical				26. Place of Dea	th (Check only one		20.10
>	nyeic nis ce direc	ToE	examiner? 1 ☐ Yes 2X No	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA Othe	or: 4 Nursing He	ome 5 Resider	nce 6 Other (S	ipecify)
0	Attending Physiclen: r death. sctor: After this certification by the funeral director, in		27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		at ?	28d. Describe how		
Sio	tendi eath. or: A the fu	catl	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				res 2□No			
Division of Vital Records,	or Att	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str v)	eet, factory, office		28f. Location (Street) City or Town,		Rural Route Number,
_	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	alCe	29a. Certifier Certifying Physi	cian: To the best of my kno	wiedge, deat	h occurred at the tim	e, date and place,	and due to the car	use(s) and manner	r as stated.
	he Ho in 24 I he Fu pletel	edical	(Check only 2 Medical Examin- one)	er: On the basis of examina and manner stated.	tion and/or in	vestigation, in my or	inion, death occur	red at the time, da	te and place, and o	due to the cause(s)
	To the within 2. To the complet	ž	29b. Signature and title of centifier	Y 97		29c. License	number	29	d. Date signed (M	onth, Day, Year)
•			IMAL	(02/		1/	75457		フリソウ	6
			30. Name and address of person who con Michael Crowley			•	Tana -		04.554	
	ACCES TO					Dutchmans	Lane, E	aston, M	21601	
	Sta Registr		31. Date filed (Month, Day, Year)	2006 Programa Salgina	M	South				

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) May 16, 2006 Elisa 10:30ам Physician Rivera /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery 14635 Bauer Drive #205 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 11/29/1912 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Mexico 1 □ M 2√2 F 93 215-66-8433 Yrs Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location Rockville 10d. Inside City Limits nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene.

orlant: If Item 27 is marked other than "natural", or Items 23a or 28a-f ahow nother; or them 27 is marked other than "natural", or Items 23a or 28a-f ahow or only or other traust be notified at a marked of the marked 10a, State Montgomery MD 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20853 USA 14635 Bauer Drive #205 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status oe filed within 72 hours after dial Hygiene. I Hygiene. I other than "natural", or Item 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married SpeWhite Baltimore, Maryland 21215-0036 1⊠Yes 2□No Specify: Mexican à 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private School Teacher 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Guillerima Merino Sixto Rivera 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17455 Macduff Avenue Olney, Maryland 20832 Ana DeCarlo/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Chesapeake Crematory 5/20/06 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Beltsville, MD. Important: S Other (Specify 4 Donation 21. Signature Service Lic PRINTER PORTNALDI FUNERAL SERVICE, P.A. meral 9241 Columbia Blvd.Silver Spring,Md.20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Myocardial Infarction **Physician** min. resulting in death) /Medical Due to (or as a consequence of) Examiner Coronary Artery Disease
Due to (or as a consequence ot): years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed attending physicien end for use as the burial-transit Due to (or as a consequence ot) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Year 5 Other (specify) 4□Pregnant at time of death signed by the a ☐Yes 2 No 9 Unknown 9 Hinknown Part It, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificete has b irector, page 2 si autopsy performed? Yes 2 No 1 ☐ Yes Hospital or Attending Physicien: Be 25. Was case reterred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 \_\_ tnpatient Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) ို 1 ☐ Yes 2 X No 3 DOA 2 ER/Outpatient this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 5 Pending investigation 1 🔀 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death
To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certi D38457 May 18,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20906 Nakul Goy/Le MD. 3801 International Drive #211 Silver Spring, MD

DHMH 17 Rev 1/2001

State

Registrar

MAY 2 2

2006

31. Date tiled (Month,

32 Registrar's Signature

			For State Registrar	State o	f Marylan	•	artment of rtificate of			ental Hygi	ene2 () g. No.	06	17854
			Decedent's Name (First, Middle,	Last)						2. Date of Death			3. Time of Death
	Physicia		Tom Hassan Radi							May 17,	Day 2006	Year	4:00 P M
	/Medic Examin		4a. Facility Name (If not institution,	give street and nui	mber)		4b. City, Town,	or Location	of Death		4c. County	of Death	
	LAGITHI	e.	Holy Cross Hospit	<b>a</b> 1			Silver	Spring			Montgon	nerv	
	Funeral			. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Yea	r If Under		8. Date of Birth		9. Birthp	lace (State or Foreign
	Funeral Director		578-64-8135	1⊠M 2□F	66	6 Yrs.	Months Day	s Hours	Min.	(Month, Day, July 1, 1		Cour	• •
			Usual Residence of Decedent							oury r, r	333		
	show		10a. State 10b. County		10c. City	, Town or Lo	cation					1	0d. Inside City Limits
	Mar	p	Maryland Monto	nmer <b>v</b>	Silv	ver Spri	ina						1 ☐ Yes 🎗 🗌 No
	1 the	rec	10e. Street and Number	J.12011 y		VOL SPIJ	10f. Zip Code			10	g. Citizen of	What Cour	ntry?
	3e o		2009 Hickory Hill L	ane			20906				USA		
	within 72 hours after death with the Maryland ane. than "natural", or Iteme 23e or 28e-f show its Madical Exercitor must be notified a	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U.	S. 13. 1	Was Decedent of	Hispanic Or	igin? (Spec	cify Yes or No-	14. Rad	e - Americ	
"	r Ite	교	1 ☐ Never Married 2 🔀 Marrie	Armed Fo	2 😡 No	į.	f Yes, specify Cu			tican, etc.)		ck, White,	etc.
33	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gir Year or D			1⊡Yes 2√⊡N	o Specify:			Specif	White	
21215-0036	2 hor	Completed	15. Decedent's				dent's Usual Occ			_ 1	6b. Kind of B	usiness/In	dustry
715	n o	pje	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (	1-4or 5+)	life.	kind of work don DO NOT use reti	e auring mos red)	t or workin	g			
7	r the	E	Clotheritary/oddoridary (0 12)	4	. 40.017	Rea]	Estate A	gent.			Real Est	ate	
	othe	ВеС	17. Father's Name (First, Middle, La	ist)				_	er's Name	(First, Middle, M	laiden Sumar	ne)	
Maryland	12 should be filed within 7 h and Mental Hygiene. 7 is marked other then " fraumatic svent, the Med	To B	Abdul-Sada Al-Rad	i				Zan	oba <sub>Uni</sub>	known			
2	Shound Na M		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Stre			Route Number,	City or Town	State, Zip	Code)
	allth a		Elba Radi/Wife			2009 F	lickory Hi	11 Lane	, Silve	er Spring	, MD 209	906	
ē,	T He a		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of natory or other p	(aca)	Da	ate 2	Oc. Location		wn, State
20	1 1 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State		in Cremato	1 .	May 200	28,	Alexandr	ria. Vi	minia
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or iteme 23e or 28e-1 show in properant: If item 27 is marked other then "naturel", or iteme 23e or 28e-1 show in your other traumatic event, it is Marical Examinational perceiting an appres.		21. Signature of Funeral Service Li		1200	-						, V.	
Ba	Dep Impo			7 (.0						al Home I		20001	
			23a. Part1. Enter the disease, of o	omplications that	aused the death					Silver Spr		20901	Approximate
			shock, or heart failure. List or Immediate Cause (Final	nly one cause on e	each line.			, 3.		, ,			Interval Between Onset and Death
	Physician		disease or condition resulting in death)		astama Mui		<u> </u>						
1	/Medical Examiner		in addition	Due to	(or as a consequ	uence of):							
		_	Sequentially list conditions,	b. Seizur	es (or as a consequ	uanna of):							
	sit sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	8									
	and tran	carr	that initiated events resulting in death) Last	U	tive Heard (oras a consequ		re						
50,	be executed sician and burial-transit	E E			12.1								
8760,	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	dical	`	d. Diabete	es Mellit	us, Type	5 TT						
9 X	ding p	Me	IF FEMALE:	030 16.000 000	tcome of pregna								
Вох	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live t	oirth 2 Fetal	death 3	Ectopic pregnar					ite of delive onth	ery Day Year
0	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregr 9□ Unkn	nant at time of de own	eath 5	Other (specify)						,
9.	es that the death cer igned by the attendir be detached for use	Physician/Me	Part II. Other significant condition	E contribution to d	eath but not rock	ulting in the u	adarhina agusa	awan in Bart I		23e Did tob	3000 HEB COD	tribute to th	ne cause of death?
Ś	res th	Completed by					ilderlying cause i	given in Fan			s 2 No		ably 4 🛣 Unknown
20	w requir been si should	ted	History of Methici	Llin-Resist	ant Bacte	eremia				10.18	2 2 140	3 1 100	ably 4 Klonknown
e C	> 11 ()	pje								24a. Was an autopsy	24b.	Were auto	psy findings available mpletion of cause of
<u> </u>	The ate has page	Ö								perform		death?	2 □ No
'ita	sian: artific ctor,	Be (	25. Was case referred to medical examiner?						e of Death	(Check only one	)		
=	Physician: this certific ral director,	2	1 ☐ Yes 2 € No	Hospital: 1 反	Inpatient 2	ER/Outpatier	t 3□ DOA	Other: 4 🗆 Nu	ursing Hom	ne 5 ☐ Resider	nce 6 🗆 Oth	ner (Specif	y)
Division of Vital Records,	5 je		27. Manner of Death 1 Statural 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28c. In	jury at lork?	2:	8d. Describe ho	w injury occur	red	
.0	Attending r death. ector: After by the fune	ati	2 ☐ Accident investiga				M 1	☐Yes 2☐	No				
ĭŽ	r Att	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad   288. Place	of Injury - At ho ing, etc. (Specify		eet, factory, offic	е	2	8f. Location (Str. City or Town,	eet and Numi State)	ber or Rura	l Route Number.
0	rs aff	Š											
	hour une une lil kie	edical		Physician: To the									
	To the Hospital or Attendity within 24 hours after death. To the Funeral Director: A completely filled in by the fu	led	one)		ner stated.				3400.10				
	To To	Σ	29b. Signature and title of certifier	11	0.5	1	29c. Lice	nse number		29	ld. Date signe		Day, Year)
•	$\sigma_{l}$		Blight Scho	ellme	un M	رر.		D41752			May	17, 2	2006
	10		30. Name and address of person w										
_			Bergit I. Schoell	man, M.D.	1500 Fo:		en Road, S	ilver S	pring,	MD 20910			
	Sta		31. Date filed (Month, Day, Year)		Registrar's Signa	ture	ule						
	Registr	ar	MAY 2 2	ZUUb MA	Euro A	19							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Midgle, Last) **Physician** 55 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chestertown Chester River Manor Kent 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 ☐ M 25 F 214-60-7589 57 Director November 4, 1948 Chestertown, MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show other treumatic event, the Medical Examiner must be notified at Chestertown XXYes 2 No Maryland Kent Director 10e. Street and Number 512 Washington Avenue 10g. Citizen of What Country? 10f. Zip Code 21620 U.S.A. Itеms 23a Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1X Never Married 2 ☐ Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify. White Specify: by 3 Widowed 4 Divorced "natural". Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Medical Laundry Assistant 9th 17. Father's Name (First, Middle, Last) if Health and Mental Hygi item 27 is marked other 18. Mother's Name (First, Middle, Maiden Sumame) Be Ralph Bradford Russum Mary Alice Mulford ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21620 1. MD Ralph B. Russum/Father 402 Morgnec Road, Apt. 2B, Chestertown, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of H
Importent: If ite
any injury or of Maurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Chester Cemetery May 25, 2006 Chestertown, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Daniels & Hutchison Funeral Home 212 N. Broad St., Middletown, DE 23a. Part1. Enter the disease) of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician resulting in death) /Medical Examiner 0 PM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physicien: The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of) Box 68760. the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death ō in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ pe 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 No this certificate 1 Yes 1 Tyes 25. Was case referre o medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient examiner? Other: Certification; To 1 Yes 2 🖪 No 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. May of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funerel Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospitel Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the Signature and title of 29d. Date signed (Month, Day, Year) 29b ame and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

**Edmek** 

31. Date filed (Month, Day, Year)

3 Strengton

MAY

24

2006

32. Registar's Signature

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death  1- For Registrar  Certificate of Death  Reg. No.								
			Decedent's Name (First, Middle, Last)     2. Date of Death	3. Time of Death							
н	Physici		NUMBA SUSSIAN IMAT II. ZUUD	7:15 A M							
hi.	/Medic Examin		4b City Town or Location of Death								
	LXAIIII	٠.		TGOMERY							
	Funeral		5. Social Security Number  6. Sex  7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)  9. Edward of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)							
	Director		208-03-1769 1 MAY 10, 1916	PA							
	D > 00		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits							
	aryla shov	_	Tod. State	1 X Yes 2 No							
	he M	ecto	MARYLAND   MONTGOMERY   SILVER SPRING   106. Street and Number   107. Zip Code   109. Citizen of What	Country?							
	a or	급	3310 NORTH LEISURE WORLD BLVD. #903 20906 U								
	eath	era	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or Nofit Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - Armed Forces?  15. Was Decedent of Hispanic Origin? (Specify Yes or Nofit Yes, specify Cuban, Mexican, Puerto Rican, etc.)	.S.A. merican Indian,							
· _	r Hend	핊	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, W								
8	urs a	þ	If Yes, Give 1 Yes 2 No Specify: Specify: Specify:	WHITE							
9	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28a-f show then "natural be ricitified at the Medical Examiner mant be ricitified at	Completed by Funeral Director	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working	ss/Industry							
2	ithin 199.	ng u	Elementary/Secondary (0-12) College (1-4or 5+)								
'n	ed w ygier ygier her th	So	DANCE TEACHER	BALLET							
Ē	be fill tal H d ott	Be	17. Father's Name (First, Middle, Last)  PETER LAIBMAN  18. Mother's Name (First, Middle, Maiden Sumame)  BESSTE GROSSMAN								
3	ould Mer narke	P <sub>C</sub>	PETER LAIBMAN BESSIE GROSSMAN  19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State	Zin Codol							
Ma	d2 sh h and 7 is n traur		19a. Informant's Name/Relationship (Type, Print)  FREDA R. MAZIS/DAUGHTER  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 9805 SOTWEED DRIVE, POTOMAC, MARYLAND	20854							
a)	1 and Healt em 2		20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City								
2	Te in age		1 ⊠ Burial 2 □ Cremation 3 □ Removal from State  1 □ Donation 5 □ Other (Specify)  1 □ Donation 5 □ Other (Specify)  1 □ Donation 5 □ Other (Specify)  1 □ Donation 5 □ Other (Specify)	MADAT AND							
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if I tem 27 is marked other then "natural", or Items 23a or 28a-f show any injury of other traumatic event, the Medical Examinar mant be inclifted at once.		^4 □Donation 5 □Other (Specify) MT. LEBANON CEMETERY 05/14/2006 ADELPHI,  21. Signature of Fuperal Service\Licensee								
Ba	Period Pe		21. Signature of Fuperal Service Licensee  22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 ROCKVILLE PIKE, ROCKVILLE, MARY	, INC.							
	*		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	YLAND 20852 Approximate Interval Between							
	Physician		A A A A A A A A A A A A A A A A A A A	Onset and Death							
	/Medical		Immediate Cause (Final disease or condition resulting in death)  a. Acute Korre failure  Due to (or as a consequence of):								
	Examiner		Cardine ischemia								
	B =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):								
	acute ind trans	Examiner									
760,	e be executed /sician and e burial-transit	ũ	Due to (or as a consequence or):								
687	icate t physic	dical	d								
9 ×	ding	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of c	folivore							
Вох	atten for u	clan	23b. Was decedent pregnant in the past 12 months?  1	Day Year							
P.O.	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Physiclan/Medi	1   Yes 2   Tho 9   Unknown 9   Unknown								
	that ned b deta	by PI		to the cause of death?							
rds	quire; n sig uld bu	q pa	1 Yes 2 No 3	Probably 4 Dunknown							
00	aw requires s been si s should I	Completed	Delicium 24a. Was an 24b. Were	autopsy findings available							
Re	The lav te has age 2	Elo	autopsy prior to death	to completion of cause of ? es 2□ No							
ţ	an: rtifica stor, p	BeC									
<b>1</b>	nysica nis ce direc	To		pecify)							
Division of Vital Records,	Attending Physician: or death. ector: After this certifical by the funeral director.										
sio	eath. or: A	catl	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be 389 Place of Injury At home farm street factory office.  281 Incation /Street and Number or								
Ξ	i or Att	Certification;	3 Suicide 4 Homicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or City or Town, State)	Hural Houte Number,							
	pital ours a eral I	S	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner	as stated							
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only one)    Check only one)    Check only one)    Check only one)								
	o the	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo	inth, Day, Year)							
)	3		May 16 Wille mos D55258 May 19 20	00 6							
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								
_			Gang & willes, mo 6121 montrove hand hockville mo 2019	12							
		ate	BARRY SEZ TRICE ON THE TANKS OF THE TRANSPORT								
14.	Regist	ar	HISTORY OF LOOK OF THE PARTY OF								

		1 - State Registrar		artment of Health and rtificate of Death	Mental Hygie	2000	1785
Physici /Medi		1. Decedent's Name (First, Middle, Last)  Norris Eugene Sword	sr.		2. Date of Death Month	Day 2006	3. Time of Death
Examir	er	4a. Facility Name (If not institution, give street and number) Washington County Hosp		4b. City, Town, or Location of Dear Hagerstown,		4c. County of Death Washingt	on
Funeral Director		220-18-3119 ¹\\\ <sup>1</sup> \\\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ <sup>1</sup> \\ 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If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthp Cour 5, 1925 M	place (State or Foreigntry) ID
h the Maryland r 28a-f ehow	tor	Usual Residence of Decedent  10a. State 10b. County MD Washington	10c. City, Town or Lo Hagerst			1	0d. Inside City Limit
death with the Maryland ms 23a or 28a-f ehow	Funeral Director	10e. Street and Number 13026 Orchid Drive		10f. Zip Code 21742	10g	. Citizen of What Cour	ntry?
<u> </u>	þ	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Exammed Forces?  1 ☑ Yes 2 □ No If Yes, Give Year or Dates:		L Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ሺ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
within 72 ane. than na	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12th grade 0  College (1-4or 5+	(Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired) Ceman	rking 161	b. Kind of Business/Ind sand blas mfg.co	
d 2 should be filed v th and Mental Hygie ? I e marked other treumatic event, tt	To Be C	17. Father's Name (First, Middle, Last) Grover Bricker Sword	Sr.		me (First, Middle, Mai Leona Ca		
es 1 and 2 shoi of Health and N I Item 27 Ie ma r other treuma		19a. Informant's Name/Relationship (Type, Print) Peggy A. Sword wife		ng Address (Street and Number or Re) 26 Orchid Dr.		-	
permit. Pages 1 a Department of Hea mportant: If Item nny injury or othe		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo cemetery, crer Blairs V	natory or other place) Ma		c.Location - City or To Lear Spri	
permit. Pages 1 Department of H Important: If Ite eny injury or ot once.		2) Signal of Funeral Service Gensile		Name and Address of Facility Oonald Edwin Th	nompson F	Tuneral H	ome,Inc
Physician /Medical Examiner	Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury		er the mode of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onse; and Death
ficate be executed physicien and s the burial-transit	edical Exa	that initiated events resulting in death) Last c.  Due to (or as a d.	consequence of):				
death certii e attending d for use a	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ny Day Year
requires that the de een signed by the a nould be detached		Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying cause given in Part I.	23e. Did tobac	co use contribute to th	
The law ate has b page 2 st	Completed				24a. Was an autopsy performed	prior to con death?	osy findings available projection of cause of 2 No
sicie: certil	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 256No Hospital: 1 ≯ Inpatient	2 ER/Outpatien	0+	ath (Check only one)		
To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification; T						
vital or At ars after or ral Direct lled in by		4 Homicide determined 286. Place of Injury building, etc.	City or Town, S	tion (Street and Number or Rural Route Number, or Town, State)			
To the Hospital or within 24 hours afte To the Funeral Dir.	Medicai	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of e and manner state	xamination and/or inv	estigation, in my opinion, death occu	rred at the time, date	and place, and due to	the cause(s)
To with	2	29b. Signature and title of certifier		29c. License number		Date signed (Month, D	Day, Year)
-6+1		30. Name and address of person who completed cause of deal Dr Wastem 1126	oth (Item 23a) (Type, 1	Print) Hagers	town Me	aryland	
Sta		31. Date filed (Month, Day, Year) 32. Registrar	s Signature	1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** William Elmer SCHNEIDER 23:28 M mar 21 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year)
Dec. 31, 1942 9. Birthplace (State or Foreign Country)
Illinois 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F 63 339-36-1480 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17723 Garden View Road 21740 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. or Iteme 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) designer-draftsman concrete permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 Ie marked otherny injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Elmer Schneider Marjorie Carsten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Schneider - wife 17723 Garden View Rd., Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition PDBurial 2 □ Cremation 3 □ Removal from State 5/27/06 Rest Haven Cemetery Hagerstown, Maryland 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Licensee 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Hy Dertensian **Physician** 20 years disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 2 □ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed aenc 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 1 ☐ Yes 2 1 No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Ne 1 Inpatient 2 ER/Outpatient 3□ DOA Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funeral Dire 1 Contitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D0038968 who completed cause of death (Item 23a) (Type, Print) 24 N Walnut St endleton-1899le OH-15 32. Segistrar's Signature 31. Date filed (Month, Day State Registrar

			1 10400	State of Ma	nyland	d / Dens	rtment of	Health	and Me	ental Hyd	riene	_09,5,0		
ame	end ite	m# *	1- For State Registrar 4a, per ph	y, bg 5/19/0	1 <b>y</b> (21 1) 5	•	tificate o				leg. No.	2006	) 178	359
			Decedent's Name (First, Middle, L.)							2. Date of Dea			3. Time of Do	eath
	Physici		William K	Aymond	.5	han	holt>			Month	14	المُكُلِّعُ الْمُعَالِمُ الْمُعَالِمُ الْمُعَالِمُ الْمُعَالِمُ الْمُعَالِمُ الْمُعَالِمُ الْمُعَالِمُ الْمُعَالِمُ المُعَالِمُ المُعالِمُ المُعَالِمُ لمُعَالِمُ المُعَلِمُ المُعَلِمُ المُعَلِمُ المُعَلِمُ المُعَلِمُ المُعَلِمُ المُعَلِمُ المُعَلِمُ المُعَلِمُ المُعَلِمُ المُعَلِمُ المُعَلِمُ المُعَلِمُ المُعِلِمُ المُعِلَمُ المُعِلَمُ المُعِلَمُ المُعِلِمُ المُعِلِمُ المُعِلِمُ المُعِلِمُ المُعِلِمُ المُعِلِمُ المُعِلَمُ المُعِلَمُ المُعِلَمُ المُعِلَمُ المُعِلَمُ المُعِلَمُ المُعِلَمُ المُعِلِمُ المُعِلِمُ المُعِلَمُ المُعِلِمُ المُعِلَمُ المُعِلِمُ المُعِلِمُ المُعِلِمُ المُعِلِمُ المُعِلِمُ المُعِلِمُ المُعِلِمُ المُعِلِمُ المُعِلِمُ المُعِلِمُ المُعِلِمُ المُعِلِمُ المُعِلِمُ المُعِلِمُ المُعِلِمُ المُعِلِمُ المُعِلِمُ المُعِلِمُ المُعِمِلِمُ المُعِلِمُ المُعِلِمُ المُعِلِمُ المُعِلِمُ المُعِمِلِمُ المُعِلِمُ المُعِلِمُ المُعِلْ	2100	М
plan.	/Medio Examir		4a. Facility Name (If not institution, ga	ive street and number)		1277	4b. City, Town	, or Locatio	n of Death		4c.	County of Deat	h	
				ospice At T			Salisb					icomico		
	Funeral			Sex 7. Age 1 M 2 ☐ F		ast birthday) Yrs.	If Under 1 Ye Months Day		s Min.	3. Date of Birth (Month, Day	, Year)	Co	hplace (State or F untry)	-oreign
	Director		213-72-8498 Usual Residence of Decedent	<i>/</i>	50	113.				02/04/1	1956	Mar	yland	
	yland sow		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City	
	Mar.	ģ	MD Somer	set	Pri	ncess	Anne						1 ☐ Yes 2	No
	I within 72 hours after death with the Maryland liene. r then "natural", or Iteme 23a or 28e-f ehow the Medical Examinar must be modified at	Director	10e. Street and Number				10f. Zip Code	9			10g. Citi	zen of What Co	untry?	
	ath w		33397 West Post					21853				USA	·	
	irems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		5. 13.	Vas Decedent of Yes, specify C	of Hispanic ( uban, Mexic	Origin? (Spec can, Puerto Ri	fy Yes or No- ican, etc.)		<ol> <li>Race - Ame Black, White</li> </ol>		
36	i', or	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 □ No If Yes, Give Year or Dates:	) 373-7	75	□ Yes	lo Speci	fy:			Specify:	hite	
21215-0036	72 hou nature	ted	15. Decedent's I	Education		16a. Deced	ient's Usual Occ	cupation			16b. Ki	nd of Business/		
215	within 7. ene. then "n	ple	(Specify only highest g Elementary/Secondary (0-12)	rade completed)  College (1-4or 5+	.)	life. l	kind of work do OO NOT use ret	ne during m ired)	iost of working	7				
	Hygien Hygien ther th	Completed	12	none		Weld	er					fense P	roducts	
n	be fill d oth	Be	17. Father's Name (First, Middle, Las							First, Middle,	Maiden	Sumame)		
2	d 2 should th and Mer 7 ie marke traumatic	၉	Raymond Junior S: 19a. Informant's Name/Relationship			10h Mailie	a Address /Cter		lla Mac		- City o	r Town, State, 2	Zin Coda)	
Maryland	d 2 sh th and th and 17 ie m traum		Linda Lee Boone-		ife		•						ne, MD 2	1853
	s 1 and if Healt item 2 other		20a. Method of Disposition			177	sition (Name of natory or other p		Da			cation - City or		
e E			1 ☐ Burial 2 Cremation 3 4 ☐ Donation 5 ☐ Other (Spec				Cremat		05/16	/2006	Sa1	isbury.	Marylan	d
Baltimore,	교원들 .	(	21. Signature of Funeral System Lic	see 🕥	, Duz.		Name and Adi						11012 ) =	
<u>m</u>	Depa Impo any i		AMUS TA	-/-//-	0295	11	1673 Sor	nerset	Ave.	Princ	ess	Anne,	⊕ 21853	
н			234. Part1. Enter the disease, or co- shock, or heart failure. List only	mplications that caused to y one cause on each line	he death	. Do not ent					rest,		Approximate Interval Betwe	
	Physician		Immediate Cause (Final disease or condition  Metastatic Lune Cancel											
	/Medical Examiner		resulting in death)	Due to (or as a	consequ	ence of):	()							
		10	S. wentially list conditions  b  Due to (or as a consequence of):											
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury											
Ć	be executed sician and burial-transit	Exa	resulting in death) Last	Due to (or as a	consequ	ence of):								
1260	te 7. 6	cal		d.										
<b>68</b>	The law requires that the death certificat is bas been signed by the ettending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE:					0.00	-					-
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal	death 3	Ectopic pregna				10:	23d. Date of del Month	ivery Day Ye	ar
o.	at the de by the e tached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	me of de	eath 5∟	Other (specify)							
<u>α</u>	that the by detail		Part II. Other significant conditions	contributing to death bu	t not resu	Ilting in the u	nderlying cause	given in Pa	rt I.	23e. Did to	bacco u	ise contribute to	the cause of dea	ıth?
Vital Records,	quires n sign	d by								××	es 2 [	⊒No 3⊟Pr	obably 4 □Uni	known
Ö	law requir as been si 2 should	Completed									4a. Was an 24b. Were autopsy finding			ailable
æ	The tay	mo								autop: perfor	med?	death?	completion of cau	SO 01
ita	ician: T certificet rector, pa	Be	25. Was case referred to medical examiner?						ace of Death (	Check only or				
of V	Physician: this certific al director,	P	1 ☐ Yes VNo			ER/Outpatien	3 DOA					6 □Other (Spe	city)	
n o	fter	ion:	27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury		liury at Vork? Yes 2	1	3d. Describe h	ow injur	y occurred		
Division	Attending or death.	icat	2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	be One Bloom of Injur	ry - At ho	me farm str				If. Location (S	treet an	d Number or Ru	ıral Route Numbe	or.
Ö	after after Dire	Certification:	4 ☐ Homicide determine	building, etc.	(Specify	)	,,,			City or Tow	n, State	)	_	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier Certifying F	Physician: To the best o	my knov	wledge, deatl	occurred at the	time, date	and place, an	nd due to the o	ause(s)	and manner as	stated.	
	he Ho in 24 he Fu pletel	Medicai	(Check only /2 Medical Ex-	aminer: On the basis of and manner stat	ed.	ion and/or in								
	To the within 2 To the complet	₹	29b. Signature and title of certifier	1/1/	1		29c. Lice	ense numbe	or O — C.	2	29d. Dat	e signed (Mont	h, Day, Year)	
•		(	Well	- CAN	N)		$\bot D$	16.	118		2.	-13-6	(6)	
			30. Name and address of person wh	o completed duse of de	ath (Item	23a) (Type,	Print)	V I	722	Cala	1.	111	21832	-
	Sta	ate	31. Date filed (Month, Day, Year)	32. Regist	's Signat	ture	0 00		())	Je0113		7-00	h. Day, Year)  6  7  7  7  7  7  7  7  7  7  7  7  7	
	Regist		MAY 1	9 2006	Mer	·K	Spark	,						

06-03616 Kristian Sebold

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certifi	cate of L	Death		R	eg No	200	0 1/86	
Physici Medical Exami		1 Decedent's Name (First, Midd						2. Date of Dea Month	Day	Year	3 Time of Death 1214 hrs	
-		Kristian James 4a. Facility Name (if not institution	on, give street and nu	umber)	4b	City, Town, or Locat	ion of Death	May 29, 2		unty of Death		
1		Johns Hopkins Hospi	tal			Baltimore						
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs last b	irthday)		Under 24Hrs		rth(MM/DD/Y	Foreio	thplace (State or in	
Director		219-73-2664 Usual Residence of Decedent	1_XM 2_F		Yrs.	6 21		Nov. 8	, 200	5 Cot	untry) MD	
any		10a. State 10b County		10c. City, Tow	n or Location	·					10d Inside City Limits	
Maryland 28a-f show any d at once.	'n	MD Ceci	·l	Risi	ng Sun					:	1 X Yes 2 No	
Maryland • 28a-f sho	Director	10e. Street and Number				Of. Zip Code		1	0g Citizen o	of What Coun	itry?	
ith the Ma 23a or 28 notified	Ē	9 S. Queen Str 11. Marital Status	eet, Apt.	#1		21911			USA			
eath wi	ıner	11. Marital Status 1 X Never Married 2 M	arried Armed F	orces?		Decedent of Hispanic specify Cuban, Mexi				Race - Americ White, etc	can Indian, Black,	
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must he notified at once	y Fun	3 Widowed 4 Div	1 Yes	2 X No	1 Y	es 2 <b>X</b> No spe	cify.		Spec	city Whi	t o	
nours a	ed by	15. Decedent's Education (Spe				Usual Occupation (G of working life, DO N				of Business/Ir		
Q _ @ Q	omplete	Elementary/Secondary (0-12)	College (*	1-4 or 5+)		of working life. DO I	OT USE TEL	iled)				
215-0036 be filed within ntal Hygiene rked other tha ent, the Media	Com	U 17. Father's Name (First, Middle,	, Last)		N/A	18.Mo	ther's Name	(First, Middle, I	N/A Maiden Surn	ame)		
21215-0036 ould be filed within 72 hou to Month Hygiene s marked other than "nat ic event, the Medical Exa	Be (	Bryan Sebold						ugler				
(N 2 ~ E &	٦	19a. Informant's Name/Relations	,	1		ddress (Street and )	Number or I	Rural Route Nur				
imore, MD 2 Pages 1 and 2 shou nent of Health and N iant: If item 27 is n or other traumatie		Haley Jugler/m 20a. Method of Disposition	other	20b Place	9 S.	Queen Str	eet,	Apt. #1	, Risi	ing Sui	n. MD 2191 Town, State	
Ore ges 1 a rt of H i: If it		1 X Burial 2 Cremation		om State crem	atory or other	place)	06-	02-2006	200. Eocal	e city of	Town, State	
Baltimore, MD permit Pages 1 and 2 she Department of Health and Important: If item 27 is injury or other traumati		4 Donation 5 Other St		New 1	Bridge	Baptist C	emete	ru	Risi	ing Sui	n, Maryland me, P.A.	
Dep Dern Dern in ju		23a Part I. Enter the disease, or	MI Jal		111	S. Queen	Stree	. Foard t. Risi	tuner na Sun	ial Hor 1. MD 1	ne, P.A. 21911	
Physician /Medical		23a Part I. Enter the disease, or failure. List only one cause	complications that con each line.	aused the death. Do	not enter the	mode of dying, such a	as cardiac c	r respiratory arr	est, shock, o	r heart	Approximate Interval Between Onset and	
Examiner		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):										
_,}		Sequentially list conditions,	b.	consequence or):								
	iner	b if any, leading to immediate Due to (or as a consequence of):  cause. Enter Underlying Cause										
	Examiner	(Cleases or Fjury that Militator events resulting in death) Last Due to (or as a consequence of).										
8760, tificate be executed ng physician and as the burial - transit		77	d	÷+	27.20	C ME OF	6 10 10					
e be ex ysiciar burial	n/Medical	X UNPENDED	AMENDED			f,perME,g856	6/8/Ut	O TT 				
<b>∞</b> = E &	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy							23d Date Mont	e of delivery h Da	ay <b>Y</b> ear	
Box 6 e death cer the attendi	Physicia		4 Pregn	ant at time of death	5 Other	(Specify)						
that the done by the detached	Ph	Part II. Other significant condit			ng in the und	erlying cause given in	n Part I	23e Did to	bacco use co	ontribute to th	he cause of death?	
P.C. ires that signed to be deta	þ							1 Yes	2 🗸 No	3 Proba	ably 4 Unknown	
ords	olete							24a Was autop			opsy findings available ompletion of cause of	
Reco The law cate has	Completed			_			_	perfor	med?	death? 1 ✓ Yes	·	
tal Rectian: The certificate ector, page	Be	25. Was case referred to medica examiner?	Heenitel:			26.Place of Dea		only one)			lemanus	
Division of Vital Records, tal or Attending Physician: The law requir rs after death al Director: After this certificate has been shed in by the funeral director, page 2 should the	욘	1 Yes 2 No 27. Manner of Death			Outpatient 3  Time of Injur			g Home 5	Residence			
ion of tending Pheath	ertification:	1 Natural 5 Pend	28a. Date (Month ding <b>unk</b>	, Day, Year)		1 Yes 2		infant as	, ,			
ViSion Atte	fica		d not be	e of Injury - At home,		actory, office building					al Route Number, City	
Div spital or cours afte neral Dis	Cert	4 X Homicide deter	mined (Specify)	Residence	_			Rising St	n, MDS.	Queen :	al Route Number, City St. Apt #1	
Division of Vital Records, P.O. Box 6  To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death To the Funeral Director: After this certificate has been signed by the attendi				t of my knowledge, de							1	
To t To t	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated  29b Signature and title of certifier  29c. License number  29d Date signed (Month, Day, Year)										
		(al 111	001	A=1		O.C.M.E.			May 30,			
	ŀ	30. Name and address of person	who completed caus	se of death (Item 23a)								
			Assistant Medic		11 Penn S	Street, Baltimore	e, MD 21	201				
St Regist	_	31. Date filed (Month, Day, Year) JUN 2 2006	Status.	gistrar's Signature	W							
	_											

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 17861

		1- For State Certificate of Death	70	Reg. N	0	00 1700
Physici	an/	Decedent's Name (First, Middle,Last)		ate of Death		3. Time of Death
edical Exami	ner	Kellie Dawn Serrano	Ma	onth ay 20, 2006	Year	0836 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location	tion of Death		4c. County of D	eath
		1416 Pinelake Lane Bowie			Prince Ged	orge's
Funeral				Date of Birth (MI		Birthplace (State or
Director		213-88-9294 1 M 2XF 42 Yrs. Months Days Ho	lours Min.	May 5, 1		<sup>oreign</sup> <sup>Country)</sup> Ok1ahoma
方面。 第四個的語言 第四個語 第四個語 第四個語 第四個語 第四語 第四語 第四語 第四語 第四語 第四語 第四語 第四		Usual Residence of Decedent	P.	lay J,	1904	OKTAHOMA
, či		10a State 10b. County 10c. City, Town or Location				10d. Inside City Limits
d how	_	Maryland Prince George's Bowie				1 X Yes 2 No
rvlan a-f sl	cto	10e. Street and Number 10f. Zip Code		10a. C	itizen of What	Country?
or 28	Director					,·
in the Maryland 23a or 28a-f show any notified at once.		1416 Pinelake Lane 20716  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic	Osisio2 / Sacot.	US		and the second second
tems items	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexi			White, e	merican Indian, Black, tc.
or i	Ē	1 Yes 2 X No 3 Widowed 4 Divorced if Yes, Give Year 1 Yes 2 X No spec				•
s afte	þ	or Dates:		14Ch	Specify: W	
hour mate	ompleted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (G during most of working life. DO N		one lob	Kind of Busine	ess/industry
36 in 72 han '	ple	College (1-4 of 5+)				
Vidh With	mo	12 Administrative As	SSISTANT other's Name (First		I.N.S.	
Hied dott	O	10.No.			•	
21215-0036 bld he filed within 72 hours after death with the Marvland Mantal Hygier than "natural", or ttems 22a or 28a-fish marked other than "natural", or ttems 22a or 28a-fish e event, the Medical Examiner must be notified at once	o Be		atricia I			
through and N	Ĕ				,	state, Zip Code)
		Andrew G. Serrano III/ Husband   1416 Pinelake L				
or Health		1 X Burial 2 Cremation 3 Removal from State Crematory or other place)  Lakemont	y, Date	200	: Location - Cit	y or Town, State
Page Page sents	l g	4 Donation 5 Other Specify: Lakemont Memorial Gardens	- 05/26/	′2006 T	)avidso	nville, MD
Baltimore, permi Pagos I ar Department of Hee Important: If ite	ľ	21. Signature of Euneral Service Licensee 22. Name and Address of Fa				neral Home
	ę v	16000 Annapo				
hysician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a failure. List only one cause on each line.				Approximate Interval
Medic I	6 8	Immediate Cause (Final disease a. Acute Alcohol Intoxication				Between Cnset and Death
xaminer		or condition resulting in death)  Due to (or as a consequence of):				
		Sequentially list conditions, b.				
	Jer	if any, leading to immediate Due to (or as a consequence of):				
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated				
cuted and transit	Exa	events resulting in death) Last Due to (or as a consequence of):				
		X UNPENDED AMENDED item#23a,27,28a-f,perME,C856,	6/9/06 TT	_		
. 39, tuest ne eve per social of	n/Medical	MENDED Item#23a,2/,28a-f,pen*E,0856,	,0/8/00 11	100	-0.00	
The United	Ž	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the		2	3d. Date of del	
	ciar	23b Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ect 4 Pregnant at time of death 5 Other (Specify)	Topic pregnancy		Month	Day Year
	Physicia	1 Yes 2 No 9 Unknown 9 Unknown		- 1		
	4	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	in Part I. 2	23e. Did tobacc	o use contribut	e to the cause of death?
	ģ			1 Yes 2	No 3	Probably 4 🗸 Unknown
tdS, Togain been a hould b	Completed			24a. Was an		e autopsy findings available
Records, The law require Teate has been so	ple		[	autopsy	prior	to completion of cause of
Rec The L	E O		1	performed*  Yes 2		Yes 2 No
The state of the s	Be C	25 Was case referred to medical 26.Place of De	eath (Check only o	ne)		,
Search Shists of direct	o B		4 Nursing Hon	ne 5 Resid	dence 6 🗸 0	ther: Scene
3 4 2 2	Ţ.:	27 Manage of Dooth 200 Date of Joines   200 Time of Joines at M	Work? 28d.	Describe how in	njury occurred	
5 4 4 B	Certification:	Natural 5 Pending FNd 5/20/2006 Fnd 8:15 am	2XX No un	k		
CIVIETO for the dead of Directors led in by the	ica	2 Accident Investigation 3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building			and Number o	r Rural Route Number, City
A stag	i E	3 Suicide 6 A Could not be determined (Specify) House	Bow	ic. MD	1416 Pin	r Rural Route Number, City elake Lane
High High						
To the the the within 24 To the F	ica	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death				
To To	Medical	and manner stated  29b. Signature and title of certifier  29c. License num				(Month, Day Year)
		O.C.M.E.			ay 21, 2006	
		Panale Tournay, My)			ay & 1, 2000	
-		30. Name and Tyless of person who completed cause of death (Item 23a)	MD 040	04		
ar para		Pamela Southall, MD Assistant Medical Examiner 111 Penn Street, Baltim	nore, MD 2120	υI		
	tate trar	31. Date filed (Month, Day, Year)  32. Figistrar's Signature				
THE RESERVE OF LICE	التقله					

			1 - For State Registrar	State o	f Marylar	nd / Depa		t of H	ealth a	and M	_		200	5	17862
			1. Decedent's Name (First, Middle, La	ist)							2. Date of De	ath			3. Time of Death
	Physici		RUSSELL EDWIN SMULLEN	, JR.							Month MAY	Day 17	y Yea 200		9:20 P M
	/Medic Examir		4a. Facility Name (If not institution, gi	e street and nur	mber)		4b. City,	Town, or	Location o	of Death		4c.	County of D	eath	
			12508 PALERMO DRIVE					SILVE	R SPRI	NG			MONTGOM	ERY	
	Funeral			Sex	7. Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	h v. Year)	9. 8	Sirthpla Counto	ce (State or Foreign
c	Director		22, 00 3, 02	1 □XM 2 □ F	49	Yrs.	WIOTIERS	Days	,,,,,,,	.,,,,,	DEC. 23			MARYI	
	pue A		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							100	f. Inside City Limits
	laryle eho	5	MARYLAND MONTGOMER	v		SILVER S								100	1√2 Yes 2 □ No
	the A	ect	10e. Street and Number			DILIVER D	10f. Zip	Code				10a Cit	izen of What	Counta	**
	with Se or	0	12508 PALERMO DRIVE					904					USA	Country	
	ne 23	era	11. Marital Status	12. Was Dece	edent Ever in U	I.S. 13. 1	Was Deced	dent of Hi	spanic Ori	gin? (Spe	cify Yes or No		14. Race - A	merican	Indian.
(0	r Iter	F	1 X Never Married 2 ☐ Married	Armed Fo	rces?		If Yes, spec	cify Cubai	n, Mexican	, Puerto	Rican, etc.)		Black, W		
8	al', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or D	re** ates:		1 🗆 Yes	2∏ No	Specify:				Specify: \	<b>∕HI</b> TE	Ξ
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23e or 28e-1 ehow ta Mudisal Examirer musi be notified at	Completed by Funeral Director	15. Decedent's E (Specify only highest gr			16a. Deced	dent's Usua kind of wo			t of worki	na		nd of Busine		•
7	ithin	n di	Elementary/Secondary (0-12)	College (1	-4or 5+)	life. i	DO NOT us	se retired)	)		.9		_	F'ed	eration
2	led w lygier her th		12	4			COMPUT	ER AN					Aging		
and	be fi	Be	17. Father's Name (First, Middle, Las.								(First, Middle,		Surname)		
څ	narke	2	RUSSELL EDWIN SMULLEN			405 14-111-		/8:			RNICE PER		T 0		
Maryland	d 2 sl th and 7 le n traun		19a. Informant's Name/Relationship DAVID SMULLEN/BROTHER			281	ng Address 56 Re	vell	n <i>a</i> Numbe s Nec	er or Hura k Ro	Route Number	er, City o COVE	r Town, State	9, Zip C 2187	ode) 71
e) T	Heeling		20a. Method of Disposition		20b. F	Place of Disco	cition (Alam	na of	-		ate		cation - City		
ğ	or of		1 🕱 Burial 2 ☐ Cremation 3 [		State W	emetery, cremico	natory or o	ther place	)	- 5/23,					
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Manylan Depertment of Heelih and Mentat Hygiene. Important: if item 27 ie marked other than "natural", or iteme 23e or 28e-f ehow arm injury or other traumatic event, the Mudical Examiner must be notified at acts.		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Pa								isbury		
Ba	Dep		C 1 1 9/		~ ~ ~		IOIIOV	vay F	uner	al Ho	ome Pro Salisb	fess	ional	Ass	ociation
			23a. Part1. Enter the disease, or con	plications that c	eused the deat								111/21	А	pproximate
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on e	ach line.		a .4	_	$\sim$ l						nterval Between Inset and Death
7	/Medical		disease or condition resulting in death)	a. Due to (	or as a consec	uence of	an	ery	2	150	ase	-		-	
	Examiner		O constallation of the second	h	dia	lattes		nei	-L1+	1) <					
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (	or as a conseq					<u> </u>					
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760,	te be executed ysicien and e burial-transit		resulting in death) Last	Due to (	or as a conseq	uence of):									
876		dical		d							-			-	
89 x	Attending Physician: The law requires that the death certifica codesth.  crost After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use esty	by Physician/Med	IF FEMALE:	23c. If yes, out	come of pregna	nev									
P.O. Box	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live b	irth 2 ☐ Feta ant at time of d	death 3	Ectopic pro					4	23d. Date of o Month	delivery Da	ay Year
o.	y the diched	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unkno		eath 5L	J Other (Sp	ecity)							
	that	y P	Part II. Other significant conditions	contributing to de	ath but not res	ulting in the ur	nderlying ca	ause give	n in Part I.		23e. Did to	bacco u	se contribute	to the	cause of death?
rds	quire n sign	d b									1 🗆 Y	'es 2[	□No 3□	Probab	ly 4 Unknown
00	s bee	olete									24a. Was	an	24b. Were	autopsy	/ findings available
æ	sician: The law certificete hes l irector, page 2 s	Completed										med?	death	?	findings available letion of cause of
ā	ien: rtifice stor, p	BeC	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes (Check only or		101	es 2[	
>	nysic lis ce direc	ToE	examiner? 1 ☐ Yes 2 🌠 No	Hospital:	npatient 2	ER/Outpatien	t 3 DO	A Othe	_		ne 5 Resid		S □Other (St	oecify)	
0	ng Pł fter tł neral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of	of Injury h, Day Year)	28b. Time of Injury	2	Bc. Injury Work			8d. Describe h				
0	endin eath. or: A he fu	atle	2 Accident Investigation				М		es 2□	No					
Division of Vital Records,	frer d	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place	of Injury - At hong, etc. (Specify	ome, farm, stre	eet, factory	, office		2	8f. Location (S City or Tow	itreet and n. State,	d Number or	Rural R	loute Number,
	urs al			1											j
	To the Hospital or Attending Physician: within 24 hours after death and To the Funeral Directors. After this cartific completely filled in by the funeral director.	Medical	29a. Certifier (Check only one)  1 Certifying Pl 2 Medical Example	tysician: To the niner: On the ba and mann	isis of examina	wledge, death tion and/or inv	occurred a restigation,	at the time in my opi	e, date and inion, deat	d place, a th occurre	nd due to the o d at the time, o	ause(s) date and	and manner place, and d	as state	ed. e cause(s)
	othe o the	Mec	29b. Signature and title of Certifier	/			29c	License	number			29d. Date	e signed (Mo	nth, Da	v. Year)
)	6484		1/1-11	// //	1	400		111	2/	O E			_		
•	Car		30. Name and address of person who	completed cause		n 23a) (Type, I		U 7	04/	00			5-17	- 0	2006
	1,2		Dr. Christopher					Ave	., Be	thes	da, MD	208	L4		
4	Sta		31. Date filed (Month, Day, Year)	32. R	sistrar's Signa	ture									
	Registr	ar	MAY 2 2	2006	gagage.	1. 4	monte	•							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician Baila Woron Tenenbaum May 20. 2006 7:10 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🗓 F 212-54-6138 86 Director 10/19/1919 Poland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at 1X Yes 2 No Director MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1801 Montrose Road #354N 20852 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. illed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ould be fi Mental H Yitzhak Adler Sarah Mlynowski Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther Pollack - Daughter 131 Jay Drive Rockville MD 20850 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages I Department of H Important: If ite any injury or ot once. 1 X Burial 2 Cremation 3 Removal from State King David Memorial 5/23/06 Falls Church VA \* 4 ☐ Donation 5 ☐ Other (Specify) Gardons Name and Address 21. Signature of Juneral Scorce Licenses Name and Address of Facility
Lanzansky-Goldberg Memorial Chapels Inc. 1170 Rockville Pike Rockville MD 20852 Approximate Interval Between Onset and Death 1 Day Part. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Ruptured Aortic Abdominal Aneurysm **Physician** resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy for in the past 12 months? Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ page 2 should be 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 Yes 2[XNo funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 XNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending within 24 hours after death.
To the Funeral Director: A completely filled in hours. death. М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 🔯 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29h. Signature and title of D0060117 2 May 21, 2006 and? 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric J. Park MD 9901 Medical Center Drive Rockville MD 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2 2 2006 Registrar

06-03405

## Please Type or Print in Black Indelible Ink

liver Travers		State of Maryland / Department of Health and Mental Hygiene  1- For State  Contificate of Death
		Reg. No. 4 U 0 1 8
Physic Medical Exam		1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day May 19, 2006  3. Time of Death Month Nay 19, 2006  1800 hrs
ileuluai Exalli	mei	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
X i		Dorchester General Hospital Cambridge Dorchester
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
Director		Months Days Hours Min. Foreign Mary Jawo
金數縣		Usual Residence of Decedent    Sec. 2, 1966   Country)   Country
any		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
=	_	MD Dorchester Cambridge. 1 VYes 2 No
Viaryland 28a-f shod d at once	) t	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
the V	ä	610 Muir Street Apt. D 2/6/3 USA
c death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,
death or item	nue	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.
Z = 1 = 1	by F	3 Widowed 4 Divorced If Yes, Give Year, 984-1987 1 Yes 2 No specify: Specify: Black
5-0036 / C ted within 72 hours after tygiene other than "natural", the Medical Examiner	be t	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
6 n 72 h an "r ical E	Completed	Elementary/Secondary (0-12)  College (1-4 or 5+)
withi withi grene ner th	L L	Cement truck Driver Concrete Company
filed I Hyg ed oth	ပို	A = A = A = A = A = A = A = A = A = A =
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than ratic event, the Medica	o Be	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MD 2 shoulth and 1 is 1 is 1 is 1 is 1 is 1 is 1 is 1 i	-	C = 1 $C = 1$ $C =$
2 5 2 5 5		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
Baltimore permit Pages   a Department of He Important: If it injury or other		1 Burial 2 Cremation 3 Removal from State crematory or other place)
Baltimo		4 Donation 5 Other Specify: Mid Shore Cremation 6/5/06 Cambridge, MD.  21. Signature of Funeral Service Licensee 122. Name and Address of Facility 125. Name and Address of Faci
Balt permit Departs Import		21. Signature of Funeral Service Licensee  22. Name and Address of Facility 11 e v R y F u v e R a 1 H o M e , R A  23a. Art I. Enter the disease, or complications that caused the de h. Do not enter the mode of dying, such as tardiac or respiratory arrest, shock, or h. n.  Approximate Interval Between Onset and Between Onset and
Physician		23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as partiag or respiratory arrest, shock or harm. Approximate Interval
/Medical	1 7	Between Onset and Death Inc. List only one cause on each line. Acute introcerebral hemorrhage associated with hypertensive Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Cardiovascular disease and cocaine  Due to (or as a consequence of):
		Sequentially list conditions, b
	ner	if any, leading to immediate Due to (or as a consequence of):
5 M 3 G	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of):
ansit	Ě	events resulting in death) Last Due to (or as a consequence of):
teath certificate be executed that the artificate be executed to a strending physician and for use as the burial - transit	Medical	X unpended   X amended   item#1,23a,27,perME,g856.6/15/06 TT
60, ate be oblysician buria	Med	IF FEMALE: 23c. If yes, outcome of pregnancy . 23d Date of delivery
687 certifica nding p	an/I	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy  Month Day Year
Box 687 e death certific the attending p	Physician/	1 Yes 2 No 9 Unknown O Unknown O Unknown
<b>⊞</b>	چّ	9 Unknown
P.O. Bres that the designed by the be detached	by F	Less But tobacco de controlle to the cause of centre
S, F uires in sign Id be		1 Yes 2 No 3 Probably 4 V Unknown
ord w req as bee shou	plet	24a. Was an 24b Were autopsy findings available autopsy prior to completion of cause of
Rec	Completed	performed?   death? 1 ✔ Yes 2 No 1 ✔ Yes 2 No
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death at Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach	Be C	25. Was case referred to medical 26. Place of Death (Check only one)
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ding Phy After tl	n:	27. Manner of Death 28a Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
ion tendi eath tor: ,	atio	1 X Natural 5 Pending 2 Accident Investigation 1 Yes 2 No
VIS or At frer d Direct in by	ific	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City
Division pital or Attendours after death erral Director: filled in by the	Certification:	4 Homicide (Specify) or Town, State)
Hos 24 hc Fun etely		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.
Division of Vital To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certif completely filled in by the funeral director.	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
- > - 5	ğ	29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year)
		O.C.M.E. May 22, 2006
•		30. Name and address of person who completed cause of death (Item 23a)
		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
	tate	
Regis	trar	placed to produce

DHMH 17 Rev 1/2001 OCME 2006

			1 - For State Registrar	State of Maryland		artment of rtificate o		and Mental Hy	giene Reg. No. 2	06	1780	65
	Physic	an	1. Decedent's Name (First, Middle, Last)			1	1	2. Date of De	aath Day	Year	3. Time of Dea	th
V	/Medi		Veronica				Voma	MAY	11, 2	206	10:20 Y	2м
	Examir	ner	4a. Facility Name (If not institution, give:	Pkins Hospi	kal	B4Hir	n, or Location o			y of Death		
	Funeral Director		5. Social Security Number 6. Set 1006-82-7550	7. Age (Infyrs. last		If Under 1 Ye Months Day		Min. April 8. Date of Bir	15,1935	Cou	olace (State or For htry) COON, W.A.	•
	land ow		10a. State 10b. County	10c. City,	Town or Lo	ocation			<del></del>	1	10d. Inside City Lir	mits
	Many	ţ	MD Howard	E11	icot	Ė					1 <b>X</b> Yes 2 □	]No
	or 284	Director	10e. Street and Number			10f. Zip Cod	е		10g. Citizen of	What Cou	ntry?	
	ath w		4960 Webbed Fort			21043	3		USA			
Maryland 21215-0036	within 72 hours after death with the Maryland ane. then "neturef, or iteme 23e or 28e-f ehow te Modical Exeminar must be notitied at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify C 1 ☐ Yes 2 2 1	uban, Mexican	gin? (Specify Yes or No , Puerto Rican, etc.)		ck, White,	can Indian, etc. .ack	
5-0	72 ho	eted	15. Decedent's Edu (Specify only highest grade		(Give	dent's Usual Oci	ne durina most	of working	16b. Kind of B	Business/In	dustry	
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22	77 75 14 15	ខ	17. Father's Name (First, Middle, Last)	4yrs	Nur		18 Mothe	r's Name (First, Middle				
and	e d la b	To Be	Paul Voma				Mar	1		116)		
ΣŽ	2 should and Men is marke	Ĕ	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Address (Stre		r or Rural Route Numb		. State. Ziu	Code)	
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Samuel Buma/ Son					ay, Ellicot				
Baltimore,	of He of He r item		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ R		ce of Dispo	sition (Name of matory or other p	olace)	Date	20c. Location			
Ë	permit. Pages 1 Department of H Important: if ite any njury or ot once.		4 Donation 5 Other (Specify)		rch C	emetery	. 6	5/17/2006	Mankon- Cameroo		.aa est Afric	ca
3at	permit. Pag Department Important: any njury c		21. Signature of Funeral Service License	90 / //				J.B. Jenl	kins Fur	ieral	Home	
	<b>₹</b> □ = € d		1 K. D. 4 -	hall				d., Landove		2078.		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)		trav		1	Hemorr	3		Approximate Interval Between Onset and Death 5 days	
8760,	sate be executed by sicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque  Due to (or as a conseque							9.0	
P.O. Box 68	requires that the death certificate be executed een signed by the attending physicien and nould be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	eath 3	Ectopic pregnal Other (specify)				ate of delive	ery . Day Year	
	quires tha	6	Part II. Other significant conditions con	ntributing to death but not resulting to death but not resulting to the distribution of the death but not resulting to the death but not resulting to the death but not resulting to the death but not resulting to death but not resulting t	ng in the u	nderlying cause	given in Part I.		obacco use con Yes 2□No		ne cause of death?	
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ta	ician:   certifical ector, p	BeC	25. Was case referred to medical				26 Place	of Death   Check only of		1 🗌 Yes	2 🖾 No	
<b>&gt;</b>	Physician: this certific ral director,	ToB	examiner? 1 ☐ Yes 2 🕱 No	lospital:	VOutpatier	t 3 DOA	Othor	sing Home 5 ☐ Resi		ner (Specif	v)	
o uo	ing After une		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 2	8b. Time of Injury		njury at Vork? □ Yes 2 □ N	28d. Describe	how injury occur			
Division of Vital	or Al	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, offic	Ce	28f. Location (: City or Tou	Street and Numb wn, State)	ber or Rura	l Route Number,	
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	Medical	29a. Certifier (Check only one) 1 Certifying Phys	sician: To the best of my knowledger: On the basis of examination and manner stated.	edge, deatl n and/or in	n occurred at the vestigation, in m	time, date and y opinion, deat	d place, and due to the h occurred at the time,	cause(s) and ma date and place,	anner as s and due to	ated. the cause(s)	
	To the within Fo the	Me	29b. Signature and title of certifier	1111 115		29c. Lice	ense number		29d. Date signe	d (Month,	Day, Year)	
			Vame Ald	ellak MD		RE	ES-01	00	May	17	200	8
R	-(6)		Tamer Abd	mpleted cause of death (Item 2	N.	Wolfe	8tre	et Ba	ltimore	N	D 2128	7
70	Sta Registr		31. Date filed (Month, Day, Year)  MAY 9 9 2.105	32. Registrar's Signatur	A CONTRACTOR OF THE PARTY OF TH	•					-	

		1 - For State Registrar	State of M	aryland	d / Depa	artme		ealth	and M		ygiene Reg. No	-211	06	Market Villa	786
Physi	cian	Decedent's Name (First, Middle, La			_					2. Date of D Month	Day		Year	3. Time	of Death 42 M
/Med	lical		Robert V	cker	5	4h Cih	, Town, or	Logation	of Doath	May	19	200 County of		23	42 M
Exam		4a. Facility Name (If not institution, giver Union Hospital of		711n+37		4b. City		Elkto			40.	County 0	Cec.	4 1	
- F		5. Social Security Number 6. 5			ast birthday)		er 1 Year	If Under	24 Hrs.	8. Date of B	lirth	1			
Funera Directo			<b>⊠</b> M 2□F	82	Yrs.	Months	Days	Hours	Min.	8. Date of E (Month, I April	3, 9	924	New	Jers	ey
D.		Usual Residence of Decedent		140 011											
arylar show	_	10a. State 10b. County		10c. City	, Town or Lo	cation		_					10	0d. Inside (	s 2 No
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with t		10e. Street and Number 209 Adams Road				101. 2	ip Code	21904	1		Tug. Cit		S.A.	-	
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og Ph ter th	<u> </u>	27. Manner of Ceath	28a. ate of Inju	y Year)	28b. Time o Injury	f	28c. Injury Work	at	:	28d. Describ	how inju	y occurred	d		
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death PATRICK MCDOUGALL WELCOME May 14,2006 **Physician** 11:05 P M /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 28, 1936 7. Age (In yrs. last birthday) 69 yrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Months 578-72-7013 1 XM 2 ☐ F Guyana Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. S MD State 10d. Inside City Limits 28a-f show lury as other traumatic event, the Musical Examinar must be notified at Prince George's Hyattsville Director 1 X Yes 2 ☐ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 7220 25th Street 20783 Guyana "natural", or Iteme 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) a filed within 72 hours after di Il Hygiene. othar then "natural", or Item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Senior Accountant D.C. Gov't Pages 1 and 2 should be filed v nent of Health and Mental Hygie ant: If item 27 is marked othar t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wigran Welcome Albertha Prass 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Meigan Welcome -spouse 7220 25th Avenue Hyattsville, MD 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injuryer once. MD Nat'1. Mem. Park 5/20/2006 Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service 21. Signature of Furieral Service Licenses 7400 Georgia Ave. NW Wash. DC 20012 no 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transt that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 res 2 No 3 Probably 4 Unknown Completed Peripheral Vascular 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 (Propertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Attendy Physician 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Emising Dept. Brusing Dept Washing for Adv. Hospital. 7600 Carroll Av. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Humym Zen 32. Pågistrar's Signature 31. Date filed (Month, Day, Year) 20912 State MAY 2 2 2006 Registrar

	For State Registrar	State of Maryland / Depa	artment of Health and rtificate of Death	Mental Hygien	2000 1/00
hysician /Medical	Decedent's Name (First, Middle, Last)     Kenneth Eugene Wa     4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Dea	May 21	year 3. Time of Death
Examiner uneral	Fahrney Keedy 5. Social Security Number 6. Sex	Nursing Home 7. Agg (in yrs. last birthday)	Boensbero If Under 1 Year   If Under 24 Hr.	S. 8. Date of Birth	Washington
rector	316-16-4112 Usual Residence of Decedent 10a. State 10b. County	M 2□F 83 Yrs.	Months Days Hours Min	Oct. 6, 1	922 Indiana
t or 28a-1 sho be notified at Director			wn		10d. Inside City Lir 1 X Yes 2 □
Dir			10f. Zip Code		Citizen of What Country?
importent: It tem 27 is marked ofter than inauter, or items 24s of 28s1 show any injury or other treumatic event, the Marical Examiner must be notified at once.  To Be Completed by Funeral Director		2. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 1942—	21740 Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Pue  1 ☐ Yes 2 ☒ No Specify:		USA  14. Race - American Indian, Black, White, etc.  Specify: White
t, the Madical E Completed		ration 16a. Decer completed) (Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)  Soldier	prking	Kind of Business/Industry  Military
atic event, I	17. Father's Name (First, Middle, Last)  Joseph Wilford War	cen	18. Mother's Na	me (First, Middle, Maide May Davis	
traumatic event, tra Mac	19a. Informant's Name/Relationship (Typ	pe, Print) 19b. Mailin	ng Address (Street and Number or R		
or other	Brenda L. Keller -  20a. Method of Disposition  1 🔀 Burial 2 □ Cremation 3 □ R	20b. Place of Dispo cometery, crei	sition (Name of matory or other place)	Date 20c. I	Location - City or Town, State
any injury	'4 Donation 5 □ Other (Specify)  21. Size ture of Funeral 5 - vice 1 s.ns	22	2. Name and Address of Facility 0	sbo <b>r</b> ne Fune	ington,Virginia ral Home,P.A. Iliamsport,MD 217
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an signed uld be de ed by F	Part II. Other significent conditions con	ributing to death but not resulting in the u	nderlying cause given in Part I.		use contribute to the cause of death
2 2				24a. Was an autopsy performed?	24b. Were autopsy findings avail prior to completion of cause death?  1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)
uter this	25. Was case referred to medical examiner?  1 Yes 21 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 ER/Outpatien  28a. Date of Injury (Month, Day Year)  28b. Time of Injury	t 3 DOA Other: Walursing H	ath Check on! one  Home 5 Residence  28d. Describe how inju	
To the Funerel Director: After completely filled in by the funeral Medical Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, stribuilding, etc. (Specify)	eet, factory, office	28f. Location (Street a. City or Town, Stat	nd Number or Rural Route Number, 'e)
completely filled in by	29a. Certifier  (Check only one)  Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier Certifying Physical Certifier Certifying Physical Certifier Certifying Physical Certifier Certifying Physical Certifier Certifying Physical Certifier Certifier Certifier Certifying Physical Certifier C	cien: To the best of my knowledge, death er: On the basis of examination and/or inv and manner stated.	vestigation, in my opinion, death occi	e, and due to the cause(s urred at the time, date an	s) and manner as stated. In place, and due to the cause(s)
N N	29b. Signature and title of certifier	4	29c. License number		ate signed (Month, Day, Year)
State Registrar	30. Name and address of person who con Khalid Waseem M.D.  31. Date filed (Month, Day, Year)	npleted cause of death (Item 23a) (Type, 1126 Opal Court 32. registrar's Signature			, ( )

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 20, 2006 May 7:20 a M Charlotte Harrison Young /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (Month, Day, Ye Sept. 25, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 M F 1927 California 171-22-7368 78 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "neturel", or Items 23s or 28s -f show any injury or other traumatic event, the Madical Examiner must be notified at ance. 10b. County 1 ☐ Yes 2 No Director Silver Spring Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 801 Buckingham Drive 20901 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2X Married Specify: White þ If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Job Corp Counselor Counseling 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Grupp G. Roland Harrison 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 801 Buckingham Drive, Silver Spring, Maryland 20901 Kenneth Young/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 21, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2006 Alexandria, Virginia 21. Signature of Funeral Service Licens Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Respiratory Failure 1 Month /Medical Due to (or as a consequence of): Examiner Non-Small Cell Lung Cancer 2 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-trans! 5 Years+ Chronic Lung Disease Due to (or as a consequence of): ned by the attending physicien detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ete has been signed page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 ☐ No 3 Probably 4 ⊠Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 21 No 1 ☐ Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1X Natural death. 1 Tes 2 No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a tc Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai within 24 hor To the Fune completely fi (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35996 elmo nd , May 20, 2006 20

State Registrar

31. Date filed (Month, Day, Year) MAY 22 2006

Linda Burrell, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

2730 University Blvd. West, #400, Wheaton, MD 20902

Please Type or Print in Black Indelible Ink

	i lease Type of Fillit iii black ilidelible liik
Thomas E. Zimmerman	State of Maryland / Department of Health and Mental Hygiene
4 Far San Amended	State of Maryland / Department of Health and Mental Hygiene items 9&17 per fb/wichd/05-30-06/dls

2006 17870

		1-For State Amended Items 9&17 Registrar Amended item #20b	per filerin	icate of	Death 🖫	chd705	5-22-2006	dlso	000 1707
Physicia		Decedent's Name (First, Middle,Last)		_			2. Date of Dea	ath	3 Time of Death
edical Exami		Thomas Eugene Zimmer	man				Month May 13, 2	Day Yea: 2006	1233 hrs
		4a. Facility Name (if not institution, give street and	number)	41	o. City, Town, o	or Location of	Death	4c. County o	of Death
		1262 Lavall Drive			Davidsonv	ille		Anne Arı	undel
Funeral		Social Security Number 6. Sex	7. Age (In yrs. last i	birthday)	If Under 1 Ye	ear If Under	24Hrs. 8. Date of B	irth (MM/DD/YYYY	9. Birthplace (State or
Director		219-42-0335   1XM 2 F	61	Vee	Months Da	ys Hours	Min.	00 10/-	Foreign MD Country) II n k n o w n
	- 1		01	Yrs.			March	23,1945	OCCURNITION TO THE REPORT OF THE PERSON OF T
ê	- 1	Usual Residence of Decedent  10a. State 10b. County	10c. City, Tov	wn or Locatio	n				10d, Inside City Limits
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land -f sh	ţ				101 7: 0 1				
Mary 28a	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	nat Country?
death with the Maryland or items 23a or 28a-f show any must be notified at once.		1262 Lavall Drive			2103	35		USA	
ms 2.	Funeral		ecedent Ever in U.S.				n? (Specify Yes or No Puerto Rican, etc.)		- American Indian, Black,
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ifter II", o	by F	3 Widowed 4 X Divorced If Yes, Give Y	ear	1 '	Yes 2X N	o specify:		Specify	White
ours a		15. Decedent's Education (Specify only highest gr	ade completed) 16				ind of work done	16b. Kind of Bus	siness/Industry
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036 thin ne.	ш	12		Disa	abled			N/A	
5-0 ed wi iygiel other	Ö	17. Father's Name (First, Middle, Last)		"		18.Mother's	Name (First, Middle,		)
21215-0036 and be filed within 7 Mental Hygiene. marked other than cevent, the Medica	Be	Walter <del>- Eugene</del> Zimmerman				Fla	ine Douty		
21 buld bulld b Men mar	2	19a, Informant's Name/Relationship (Type, Print )		19b. Mailing	Address (Stre	et and Numb	oer or Rural Route Nu	mber, City or Towr	n, State, Zip Code)
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland and 2 should be filed within 72 hours after death with the Maryland ten 27 is marked other than "natural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once		Nina Douty Cannata/Co	usin	212	West F	ourth	Street, Le	ewes. DE	19958
altimore, MD 21215-0036 mit. Pages I and 2 should be filed within 72 hours after portnent of Health and Mental Hygiene. portnant: If item 27 is marked other than "natural", jury or other traumatic event, the Medical Examiner.		20a. Method of Disposition		ce of Disposit	ion (Name of c	emetery,	Date	20c. Location -	City or Town, State
Ore ges I t of F		1 Burial 2 X Cremation 3 Removal	Holli State	matory or othe			05/19/2006 <del>05/12/06</del>		D 1
timen real		4 Donation 5 Other Specify:			Cremato				Delaware
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene, Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		21. Signature of Funeral Service Licensee MO	0866				Homes & C		
		23a Part I. Enter the discase, or complications that	and the death. De	j 169	61 Kin	gs Hig	hway, Lewe	es, DE 19	958
Physician /Medical		failure. List only one cause on each line	. caused the death. Do	o not enter the	e mode or dym	g, such as ca	rdiac or respiratory ai	rest, snock, or nea	Between Onset and
Examiner			erotic Cardiovas	cular Dise	ase				Death
		or condition resulting in death) Due to (or as	a consequence of):						
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8 = -	n/Medical	UNPENDED AMENDED	)						
Box 68760, death certificate be ex he attending physician of for use as the burnal	Nec	IF FEMALE: 23c. If ye	s, outcome of pregnan	ncy	•			23d. Date of	delivery
876 rtificate ing phy as the	J/u	23b. Was decedent pregnant in the past 12 months?	e birth	2 Feta	al death 3	Ectopic	pregnancy	Month	Day Year
30x 687 leath certific e attending p	Ci	4 Pre	gnant at time of death	5 Oth	er (Specify)				
Box e death c the atten	Physicia		nown						
Records, P.O. Bo The law requires that the de rate has been signed by the bage 2 should be detached f		Part II. Other significant conditions contributing	to death but not resul	Iting in the ur	nderlying cause	given in Par			bute to the cause of death?
res the signe	d by						1Ye	es 2 No 3	Probably 4 🗸 Unknown
ords, w requir ts been s should!	Completed						24a. Was		Vere autopsy findings available from to completion of cause of
tal Recorcian: The law is certificate has beetor, page 2 sh	dμ						perfo	ormed? d	leath?
TT '- '5 m	ပိ				20.51			2 No 1	Yes 2 No
cian: certif ector,	Be	25. Was case referred to medical examiner? Hospital: 4	1			Othor	Check only one)	1	-
hysi r this	ဥ	1 ✓ Yes 2 No		R/Outpatient			Nursing Home 5	Residence 6	
n of ling P After funera			te of Injury nth, Day,Year)	Bb. Time of In	_	jury at Work?		how injury occurre	ea
ior: tor:	atic	Pending  Accident Investigation				Yes 2	NO .		
Division of Vital Records, la or Attending Physician: The law requirms and are death.  The Director: After this certificate has been sided in by the funeral director, page 2 should be	ific	3 Suicide 6 Could not be 28e. Pl	ace of Injury - At home	e, farm, street	t, factory, office	building, etc	28f. Location or Town,		er or Rural Route Number, City
Division of Vital Hospital or Attending Physician: 24 hours after death. Francal Director: After this certifiely filled in by the funeral director,	Certification:	4 Homicide determined (Special	(y)						
Division  Hospital or Attend 1.24 hours after death e Funeral Director: erely filled in by the	a	29a. Certifier 1 Certifying Physician: To the t	est of my knowledge,	death occurr	ed at the time,	date and plac	ce, and due to the cau	ise(s) and manner	as started
Div To the Hospital of within 24 hours al To the Funeral C	Medical	one) 2 Medical Examiner: On the bas and manne		or investigation	on, in my opini	on, death occ	curred at the time, date	e and place, and di	ue to the cause(s)
F 3 F 8	Me	29b. Signatule and title of certifier			29c. Lice	nse number		29d. Date signe	ed (Month, Day, Year)
"DA		(1)/ 6. On Do 111	$\bigcap$		0.0	C.M.E.		May 14, 20	06
Les .	1 4	30. Name and address of person who complete	se of death (Item 22	Ba)					
Jr. 7.	0 8	Laron Locke MD. Assistant Medi			Street, Bal	timore. MI	21201		
0 /4			Registrar's Signature		,	1			
S	tate	31. Date filed (Month, Day, Year) 32.							

			1 - For State Registrar		epartment of Health and Certificate of Death	Mental Hygier	2000 1101
	Physici	ian	1. Decedent's Name (First, Middle, La	Λ.,		2. Date of Death Month	Day Year 3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, giv		4b. City, Town, or Location of Dea		4c. County of Death
	Funeral Director		5. Social Security Number 6. S		(ay) If Under 1 Year If Under 24 Hr.	. (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	hours after death with the Maryland turs!, or items 23s or 28s-f show at Exact at must be redified at	ector	10a. State 10b. County  10e. Street and Number	10c. City, Town o	r Location	100	10d. Inside City Limits 1 1 Yes 2 □ No
	ath with	Funeral Director	4025 Raleic	in Road	21208		Citizen of What Country?
5-0036	ours after de rai', or items Exerciment	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☐ No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black
21215-0	iges 1 and 2 should be filed within 72 hours after death with the Marylar nt of Health and Mental Hygiene. If Itam 27 is marked other than "natural", or itema 23a or 28a-f ahow or other traumatic event, If a Medical Exart arrival to mortified at	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	Jucation 16a. De de completed) (G	ecedent's Usual Occupation live kind of work done during most of wo le. DO NOT use retired  REPLACE  R	orking	Kind of Business/Industry
Maryland 2	iould be filed I Mental Hyg Parked othe	To Be C	17. Father's Name (First, Middle Last, Pumroy R	Allen	18. Mother's Na	me (First, Middle, Maide	rmor
	es 1 and 2 sho of Health and f Itam 27 is my r other traumy		19a. Informant's Na Relationship  Pose E  20a. Method of Disposition	160/Sister 27	ailing Address (Street and Number or R	Baltine	v or Town, State, Zip Code)  Code  Location - City or Town, State
Baltimore,	permit. Pages 1 and Department of Health Important: If Itam 27 any injury or other tr once.		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of Funeral Service Licer Control of Funeral Service Licer Control of Funeral Service Licer Control of Funeral Service Licer Control of Funeral Service Licer Control of Funeral Service Licer Control of Funeral Service Licer Control of Funeral Service Co	Mt 216	22. Name and Address Facility	hatman-	radowne Md. Harris Funerallin
	40240		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Oo not	5240 Reisters town enter the mode of dying, such as cardia		Fimore Md 21215  Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):			Onset and Death
68760, <	ficate be executed physician and as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.	O TOOK EL		
P.O. Box 68	The law requires that the death certifics the has been signed by the attending ptoage 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
	w requires that been signed b should be deta	Ď	Part II. Other significant conditions of	ontributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobacco	ouse contribute to the cause of death?
of Vital Records,	w	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
Vita	ysician: Th s certificete director, pag	o Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	Othor	ath (Check only one)	6 ☐Other (Specify)
Division of	Attending Physician: or death. ector: After this certifically the funeral director.	ation: T	27. Manne of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at	28d. Describe how inj	
Divi	To the Hospital or Attending Physicien: within 24 hours effer death.  To the Fundreal Director: After this certific completely filled in by the funeral director.	il Certification:	3 Suicide 6 Could not be determined	building, etc. (Specify)		City or Town, Sta	
	tha Hos nin 24 ho the Fun npletely	fedical	one) 2   Medical Exam	ysician: To the best of my knowledge, do iner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occi	e, and due to the cause( urred at the time, date ar	s) and manner as stated.  Id place, and due to the cause(s)
	To To Con	Σ	29b. Signature and title of certifier		29c. License number D57727		ate signed (Month, Day, Year)
	2		Narendy Bl	completed cause of death (Item 23a) (Type	whet Place	Dund	5/06 lalh.mp 21222
**	Sta		31. Date filed (Month, Pay, Year)	32. Habistrar's Signature	Land .		

State of Maryland / Department of Health and Mental Hygiene 2 [] [] [5] Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** 5 June 2006 10:40 PM John G. Armstrong, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 10451 Scaggsville Road Laurel Howard If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 85 Yrs. Maryland July Director 579-16-5773 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow other traumatic event, the Medical Examiner must be notified at 1 Yes XXNo Director MD Howard Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ or iteme 23a 10451 Scaggsville Road 20723 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 X Yes 2 No 1944-If Yes, Give Year or Dates: 1946 within 72 hours after 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "neturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other then "ne eny injury or other traumatic event, tra Medic once. State Highway Elementary/Secondary (0-12) College (1-4or 5+) Foreman Administration 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Edward Armstrong Cora Schaefer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Helen Elizabeth Armstrong/Wife 10451 Scaggsville Road, Laurel, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 4 □Donation 5 □ Other (Specify) 6/8/2006 Emmanuel Cemetery Scaggsville, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee 313 Talbott Avenue, Laurel, MD 20707 M00770 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or co-shock, or heart failure. List only nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final disease or condition Metastatic Bladder Cancer **Physician** 16 Months resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner death certificate be executed attending physicien and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) page 2 should be detached 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 □Unknown 1 ☐ Yes 2XXNo Completed peed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 1 ☐ Yes XX No 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home MResidence 6 Other (Specify) 1 ☐ Yes 2 📆 📉 2 completely filled in by the funeral dir 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide XXertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier D38509 June 6, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nicholas Koutrelakos, 11065 Little Patuxent Parkway, Columbia, MD 21044

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Publistrar's Signature

			1 - For State Registrar	State of	Maryland /		artment <i>tificate</i>			ınd M	lental H	ygier Reg. I	711	06	17	873
	Physici	an	Decedent's Name (First, Middle, La	•		TDD					2. Date of D Month		Day	Y <i>e</i> ar		of Death
	/Medic	al	4a. Facility Name (If not institution, giv		HY E. F	AIRE		Town or	Location o	f Dogsh	May	30,	200 4c. County		6:50	) P M
	Examin	er	Marley Neck He				-		urni						unde1	
	Funeral		5. Social Security Number 6. S	iex 7.	Age (In yrs. last	birthday)	If Under	1 Year	If Under 2	24 Hrs.	8. Date of E (Month, L	Birth		9. Birth	place (State	
	Director		212-05-9361	□M 2 <b>X</b> F	87	Yrs.	Months	Days	Hours	Min.	05/16	/19	1919 Country) MD			)
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	cation								10d. Inside	City Limits
	Maryl -f sho	tor	MD Anne A	rundel	Pa	sade	na									s 2X No
	n the	Irec	10e. Street and Number			5440	10f. Zip	Code				10g. (	Citizen of V	Vhat Cou	ntry?	
	23e o	al D	7664 Pine Have	n Drive			21	122				U	.S.A	. •		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked othar than "netural", or Items 23e or 28e-f show any injury or othar traumatic evant, Ite Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ※ Widowed 4 □ Divorced	12. Was Decedon Armed Force 1	es? <b>⊠</b> No		Vas Decede fYes, speci I □ Yes 2		spanic Orig n, Mexican Specify:	in? (Sp , Puerto	ecity Yes or N Rican, etc.)	No-		k, White,	can Indian, etc. ite	
21215-0036	2 hour	ted t	15. Decedent's Ed	ducation		Sa. Deces	lent's Usual	Occupa	tion	-		16b.	Kind of Bu			
215	thin 72	Completed	(Specify only highest gra	ade completed) College (1-4	or 5+)	(Give lite. L	kind of worl OO NOT use	k done d e retired)	uring most	of work	ing				,	
2	ed wit	Соп	8			Home	make						wn H			
Ind	be filed vital Hygie od othar l	Be	17. Father's Name (First, Middle, Last,								First, Midd			,		
Maryland	should be nd Mental marked c	To	Roland Lewis C  19a. Informant's Name/Relationship (			Ob Mailie	- Add				Viola					
Ma	id 2 slith anith 27 is r		Linda Scally /				-				al Route Num Pasad				•	
	s 1 and f Health tam 27 othar tr		20a. Method of Disposition	Daugire	20b. Place	of Dispo	sition (Nam	e of	- 1		rasau Date	7	Location -			
9	Pages nent of I int: If its iry or o		1 X Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specif		MD V	-	natory or otl		·	6/0	5/06	Cr	ัดพุทธ	wil:	le, M	ďΤ
altimore,	permit. Departm Importal any inju		21. Signature of Saneral Service Licer		IID V						J.Gon					
m	Depa Impo any i		Men Son								e, Pa				2112	
	Pnysician /Medical Examiner	_	23a. Part1. Enter he disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate	a	as a consequence	ia	lu	0,			or respiratory		Pse		Approxima Interval Be Onset and	etween
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequenc					V				Ì		
P.O. Box 6	death certif e attending ed for use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		n 2 ∏ Fetal dea it at time of death		Ectopic pre Other (spe						23d. Date Mor		∍ry Day	Year
	- v -	by	Part II. Other significant conditions of	ontributing to deat	h but not resulting	g in the ur	derlying ca	use give	n in Part I.					ibute to th 3 □ Prob	ne cause of pably 4	death?
Vital Records,		Completed									24a. Wa auti per 1 🗆 Yes	opsy formed?	D B	Vere auto rior to cor eath?	psy findings mpletion of No	s available cause of
ξ	sicien: Th certificate irector, pag	o Be	25. Was case referred to medical examiner?	Hospital:				Othe	-	-	(Check only		V		Пег	lth
Division of	Attanding Physicien: The r death. actor; After this certificate ha actor; After this certificate haby the funeral director, page	<b>!</b>	1 Yes 2 No  27. Mannarol Death Natural 5 Pending 2 Accident investigation	28a. Date of (Month,		Outpatien Time of Injury		c. Injury Work	4 LI Nur	1	me 5 □ Res 28d. Describe			er <i>(Specif</i> ) ed	2 Cen	iter
Divis	or after in Line	Certification:	3 Suicide 6 Could not b. 4 Homicide determined	280. Place of	Injury - At home, , etc. (Specify)	farm, stre	eet, factory,	office			28f. Location City or To			er or Rura	l Route Nur	mber,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2   Medical Examone)	nysician: To the boniner: On the basi and manner	s of examination	lge, death and/or inv	estigation, i	in my opi	nion, deatl	l place, a	and due to the	, date a	nd place, a	nd due to	the cause(	(s)
	To Too	RE.	29b. Signature and title of certifier				290.	License	Turnber			290.	Date signed	(Month,	Jay, rear)	
	17		Name,and address of person who	completed cause	of death (Item 22)	a) (Tuna !	Print	در		×C	)	UU	100	710	SP	
1	-{ Sta	to.	31. Date filed (Month, Day, Year)	aloux	Istrar's Signature	IHV	<i>iSu</i>	ite	#23	IA	nnap	Olis	sm	) 2	1401	
	Registr			2006	Messer S	1. 14	bark	,			•					

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of M	arylan		artment o			ental Hy	giene	4000	17874
	Physic /Medi		Decedent's Name (First, Middle,  WILLIAM  C		SSEL	JR				2. Date of De Month リレルセ	Da O G		3. Time of Death 2: 25 A M
	Exami		4a. Facility Name (If not institution,  LAR BO &	HOSPIEML				n, or Location				n/a	1
	Funeral Director		5. Social Security Number  212-60-6055  Usual Residence of Decedent		33	last birthday) Yrs.	Months Da		Min.	8. Date of Bir (Month, Da Jan. 24	th 1 <i>y, Year)</i> 4 <b>,</b> 19.	53 Mary	nplace (State or Foreigr untry) Land
	the Maryland	Director	10a. State         10b. County           Maryland         n/a           10e. Street and Number		10c. City	y, Town or Lo Balt:		le.			10g Cit	tizen of What Co	10d. Inside City Limits  1  Yes 2 No
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland t of Health and Mental Hygiene. If items 27 is marked other than "natural", or items 23e or 28e-f show or other traumatic event. The Mcdical Examine	by Funeral Di	1424 Battery A  11. Marital Status  1X Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?	?	1	212. Was Decedent f Yes, specify C	30 of Hispanic O Cuban, Mexica		cify Yes or No Rican, etc.)	Į	United S  14. Race - Amer Black, White  Specify:	tates
Baltimore, Maryland 21215-0036	filed within 72 hou Hygiene. Ither than "natura ant, the Madical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12 years	s Education grade completed)  College (1-4or: 1 year	5+)	(Give	dent's Usual Oc kind of work do DO NOT use re Mixer	ne during mo tired)			Loc	ind of Business/l	,
ryland	12 should be filed within hand Mental Hygiene. 7 is marked other than "raumatic event, the Market	To Be	17. Father's Name (First, Middle, L William Carl Boe 19a. Informant's Name/Relationshi	essel, Sr.		19h Mailin	ng Address (Str.	Man	rgaret	F. Bo	rgar		in Condel
e, Ma	is 1 and 2 s of Health an item 27 is i		William C. Boess 20a. Method of Disposition	el, Sr. (fa	20b. P	1424	Battery sition (Name of	y Ave.	Balti	more,	MD 2	21230 ocation - City or T	
altimor	permit. Pages Department of I Importent: If it any injury or o		1 Burial 2 Cremation 4 Donation 5 Other (Sp. 21. Signature of Hunera Cervice H	ecity)		en Have	natory or other on Mem.  Name and Ad	Pk. (	5-9-20	006	G1er	n Burnie	
	Fnysician /Medical Examiner	er		a. Due to (or as	d the death ine. PATIE a consequ STRO 1	th. Do not enti- EN Counce of):	BO E. For the mode of the mode of the MALC	dying, such as	e. <u>Ba</u> 1	timore respiratory a	rrest,	P.A. 21230	Approximate Interval Between Onset and Death 3 DAUS
> '09/8	death certificate be executed e attending physicien and of for use as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as		(+0515 uence of):	LVE	R					SYEARS
.O. Box 6	at the death certific by the attending p tached for use as:	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	Ideath 3	Ectopic pregna					23d. Date of deliv Month	rery Day Year
ords, P.	w requires that the been signed by th should be detache	by	Part II. Other significant condition	contributing to death b		ulting in the ur	nderlying cause	given in Part	t.		obacco u /es 2/	,	the cause of death? bably 4 Unknown
of Vital Records,	The law ate has b page 2 si	Completed								24a. Was autop perfo		prior to co	opsy findings available ompletion of cause of
Division of Vit	ttending Phys death. ctor: After this / the funeral dir	Certification; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investiga  2 Accident investiga  3 Suicide 6 Could no determin	ot be	y Year) ury - At ho	ER/Outpatien 28b. Time of Injury ome, farm, stre	28c. lr	Other: 4 No njury at Vork? Yes 2 No	ursing Hom 28	3d. Describe h	dence (	d Number or Run	
	To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the t	edical Ce	29a. Certifier 11 Certifying (Check only one)	Physician: To the best xaminer: On the basis of and manner st	f examinat	wledge, death tion and/or inv	occurred at the	e time, date ar y opinion, dea	nd place, ar	nd due to the o	cause(s) date and	and manner as s I place, and due t	stated. o the cause(s)
)	To the within To the comple	Me	29b. Signature and title of certifier	LM KH		ΛĎ		ense number	0			e signed (Month,	
	3		30. Name and address of person w			23a) (Type, 1 HPN 0 46	Print)	BALTI		, NI		1225	
DH	Sta Registr MH 17 Rev 1/2	ar	31. Date filed (Month, Day, Year)  JUN 0 7 20	06 January	ar's Signat	Acer	( )						

**ORIGINAL** 

		í	1 - For State Registrar	State of Ma	arylar	-	artment of H <i>rtificate of</i>		Mental Hy	giene Reg. No	4 U U D	17875			
	Dhuaisi		1. Decedent's Name (First, Middle, Last)				_		2. Date of De		/ oo Xear	3. Time of Death			
	Physici /Media		Harold	David		Brow	m, Jr.		Me y	26°,		1:07 P M			
	Examir	er	4a. Facility Name (If not institution, give :				4b. City, Town, o		ath	4c.	County of Dea	ith J/A			
	Funeval		Deaton Medical Ce 5. Social Security Number 6. Sep		e (In yrs.	. last birthday)	If Under 1 Year	ltimore		rth	9. Bi	thplace (State or Foreign			
ы	Funeral Director			M 2□F	49	Yrs.	Months Days	Hours Mi	n (Month, Di	3, Year) 3,19		ountry) aryland			
	p ,		Usual Residence of Decedent  10a. State 10b. County		100 Ci	ty, Town or Lo	anting					10d Inside City Limits			
	shove	ō	Maryland N/A		100.0	Balti						10d. Inside City Limits 1 ✓ Yes 2 ☐ No			
	28a-1	Director	10e. Street and Number			Daici	10f. Zip Code			10g. Cit	izen of What C	ountry?			
	3e or	Ö	1304 S. Carey Stre	eet			212	30			U.S.A.				
	deatl	Funeral	<del></del>	12. Was Decedent I	Ever in U	J.S. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origin?	(Specify Yes or No	)-	14. Race - Am Black, Whi	erican Indian,			
98	or It	by Fu	1 Never Married 2 Married	1 ⊋Yes 2 □ N If Yes, Give	10		1 ☐ Yes 2 ☑ No	Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Specify:				
21215-0036	within 72 hours after death with the Maryland ane. then "neturel", or Items 23e or 28a-f show the Modical Examinar must be notified at	q pa	3 ☐ Widowed 4 ☑ Divorced  15. Decedent's Edu	Year or Dates:		16a Dece	dent's Usual Occup	ation		16b K	ind of Business	White			
15	in 72 n "ne	piet	(Specify only highest grade	e completed)		(Give	kind of work done DO NOT use retire	during most of w	rorking	100. K	ild of business	virioustry			
212	d withing giene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5 N/A			Depende	nt			N/	'A			
	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other then "neturel", or Items 23e or 28a-f show event. The Madral Examiner must be notified at	Be (	17. Father's Name (First, Middle, Last)	4		_	_		ame (First, Middle		,				
Maryland	12 should be filed h and Mental Hygi 7 is marked other treumatic event, II	၉	Harold	David		Brown,		Rose		С.		mberland			
Mai	2 2 2 2		19a. Informant's Name/Relationship (Ty Rose C. Craver (N				ig Address (Street					21p Code) and 21230			
ē,	item 27 other tre		20a. Method of Disposition	ioener)	20b. I	Place of Dispo	sition (Name of natory or other place		Date		ocation - City or				
E	Pages nent of 8 ont: If its		1 ☐ Surial 2 ☐ Cremation 3 ☐ R  1 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State			.1 Cemete		31/06	Bro	oklyn F	ark Maryland			
Baltimore,	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service License	96	•	3/2	Name and Addre	ss of Facility	Funeral	Ноте	. P.A.				
_	20 = 20		McCully-Polyhlak Funeral Home, P.A. 130 East Fort Ave. Baltimore, Maryland 212												
			shock, or heart failure. List only or	ne cause on each lir	10.	4		000.00				Approximate Interval Between Onset and Death			
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	MRSA S	20/10	docar	ditis wir	th sept	cemb	eli	to	marth			
U	Examiner			H = I	a consec	quence of): 6	rain, l	ungs d	Spelle			14.7			
7		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consec	quence of):	,					920			
V	acuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Cere		o vas	emla	( al	eden	0		yrs			
60,	The law requires that the death certificate be executed the sbeen signed by the attending physician and bage 2 should be detached for use as the burial-transit	E	resulting in death, cast	Holo a	L 1	quence of):	7 10					(22			
09289	icate physi s the	dicai		1. Tiefla	T(7	(/) /	2 (( (					- PX			
Box (	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome							23d. Date of de	livery			
	the atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregnancy Other (specify) _				Month	Day Year			
P.0	that the de ed by the detached	Phys	9 Unknown												
	ires tha signed s be del	þ	Part II. Other significant conditions con	itributing to death bi	ut not res	sulting in the ur	nderlying cause giv	en in Part I.		obacco u Yes 2[		o the cause of death?			
Ö	w require been sig should b	etec													
Records,	The tav	Completed								psy ormed?/	prior to death?	utopsy findings available completion of cause of			
Vital		O	25. Was case referred to medical			-		26. Place of Di	1 ☐ Yes eath (Check only	2 ☑ No	1 🗆 Yes	2 No			
ί	S S	To B	examiner?	lospital: 1 🗷 Inpatie	nt 2	ER/Outpatien	t 3 DOA Oth	00	Home 5 ☐ Resi		6 □Other (Spe	ecify)			
n of			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Da)	y Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe	how injur	y occurred				
sio	Attendii death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be	(1-1)	441			Yes 2□No	006 1	O					
Division	after of Direct Direct of In by	Certification:	4 Homicide determined	building, etc	iry - Ath . (Speci	iome, farm, str fy)	eet, factory, office		City or To	wn, State	d Number or R )	ural Route Number,			
_	spitel		29a. Certifier 1 € Certifying Phys	sician: To the best of	of my kno	owledge, death	occurred at the tir	ne, date and place	ce, and due to the	cause(s)	and manner a	s stated.			
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical	(Check only 2 Medical Examile one)	ner: On the basis of and manner sta	examina	ation and/or inv	estigation, in my o	pinion, death occ	curred at the time,	date and	place, and du	e to the cause(s)			
	To the To the Comp	Σ	29b. Signature and title of certifier	4.4			29c. Licens				e signed (Mon	1.			
)	1		· cf Mehta				Di	497	4 1	rya g	1,26	,2006			
	411		30. Name and address of person who co	mpleted cause of de	eath (Iter	m 23a) (Type,	Print)	stront	Raltin	00	MA)	1770			
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	Signa	perke	1	" xx	1341111	012,	- , - 2	, 230			
	Regist		1014 A 1 5000	BEARING A	D. 1										

State of Maryland / Department of Health and Mental Hygiene For Stata Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2006 2203 **Physician** June 5, Birsit Arthur /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 5707 Moore Street Baltimore Anne Arundel If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 8. Date of Birth (Month, Day, Y Feb 6, 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1**⊠**M 2□F Yrs. 87 215-03-3073 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hyglene. and the state of Health and Mental Hyglene. "Astural", or Items 23s or 28s-1 show ant. If item 27 Is marked other than "natural", or Items 23s or 28s-1 show ury or other traumatic event, its Medical Examinat Insat Let collised at 1 ☐ Yes 2X No Maryland Baltimore Anne Arundel Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21225 5707 Moore Street USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WW 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: ď White 3 Nidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Draftsman Airco Corp. 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pauline Herman John Birsit 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Daughter) 3219 McShane Way, Baltimore, Md. Barbara E. Birsit 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. Glen Haven Mem. Pk. 6/9/2006 Glen Burnie, Md. 4 ☐ Donation 5 ☐ Other (Specify) McCully-Polyniak Funeral Home, P.A 237 E. Patapsco Ave., Balto., Md. 21. Signature Funer Same Licensee Kevin E Ecker 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 3 mouths Physician diseese or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit the attending physicien and Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day ŏ Month Year 5 Other (specify) 1 ☐ Yes 2 ☑ Ño been signed by the should be detached 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 🗌 Yes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform has page 2 2 No certificete 2 No 1 Yes 1 🗆 Yes 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manne of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No M investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier ţ, 29c. License number 29d. Date/signed [Month, Day, Year) 29b. Signatus, and title of certifier cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

0

2006

32. Registrar's Signature

			For State	State of		nd / Depa	rtment of H		Mental Hy	giene	06	17877
			Registrar	- 1		Cel	tificate of	Death		Reg. No.		1 a T ( b
Phy	/sicia	n	Decedent's Name (First, Middle, L	1	. ,				2. Date of Dea Month	Day	Year	3. Time of Death
	ledić			Basse		-	41. O'r. T.		6		96	7:30pm
Exa	amin	er	4a. Facility Name (If not institution, g					or Location of Deal	th		nty of Death	
			Charlestown Car  5. Social Security Number 6.		7. Age (In yrs.	last hirthday)	Catons If Under 1 Year		8. Date of Birt		altimo	
Fund Direct			144-28-2257	1 XM 2 ☐ F	90	Yrs.	Months Days	Hours Min.	(Month, Da)	r, Year)		place (State or Foreign intry)
	LOI	-	Usual Residence of Decedent		90				May 25,	1910		New York
/land	74		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
Man	90	5	Maryland Baltim	ore		Catonsv	i11e					1 ☐ Yes 2K No
n the	Total I	irec	10e. Street and Number	010		, creoner	10f. Zip Code			10g. Citizen	of What Cou	untry?
h wit	2	0	715 Maiden Choic	e Lane C	C401		21228			USA		
III. Z I Z I J J J J J J J J J J J J J J J J	9	Funeral Director	11. Marital Status	12. Was Dece		.S. 13.	Vas Decedent of h	Hispanic Origin? (S	Specify Yes or No- to Rican, etc.)	14. F	lace - Amer	
after or its	min	E	1 Never Married 2 Married		2 🗌 No		i ⊓es, specilly cub i □ Yes 2X No		to riloan, etc.)	Spe	Black, White	White
ours ours	3	d by	3 Widowed 4 Divorced	Year or Da		I		оросну.		Зре	211y. ¥	WIIICC
72 h	200	Completed	15. Decedent's (Specify only highest of	Education rade completed)		(Give	lent's Usual Occup kind of work done	during most of wo	rking	16b. Kind of	Business/Ir	ndustry
Agin dithin	2	d I	Elementary/Secondary (0-12)	College (1	-4or 5+)		DO NOT use retire	d)				
lled v tygie	뒫		17. Father's Name (First, Middle, La.			Physi	Clan	19 Mother's Na	me (First, Middle,	Medic		
be fi	> >	Be	LeOwen P. Basse						. Mente	Maideil Suil	am <del>e</del> )	
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VICE 12 st h and 7 is n	ran		19a. Informant's Name/Relationship						ural Route Numbe			
paritimore, interpretable 2.12.13.70000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f ahow	ther		Dorothea Basset  20a. Method of Disposition	t Wife		709 M	aiden Che sition (Name of	oice Lane	≥ RGT1()6	Cator 20c. Locatio		Le MD 21228
Titof F	0 0		1 ☐ Burial 2 🛛 Cremation 3		State	cemetery, crer	natory or other pla					
Definit. Pages Department of I	Jury		'4 □Donation 5 □Other (Spec		ме		matory		/2006 erling As	Catons		The state of the s
De mani	any ir		21. Signature of Funeral Service LC	ensae		F	uneral H	ome of Ca	atonsvil]	le, Ind	c.	
	4 0		Julie 1		2	1	630 Edmo	ndson Ave	enue; Cat	onsvi	lle, M	
			23a. Part1. Efter the discusse, or co shock, or heart failure. List on	ly one cause on e	ach line.	Do not ent	er the mode of dyl	ng, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death
Physic	_		Immediate Cause (Final disease or condition resulting in death)	_a. Ine	umon	ia						
/Medi Exami			resulting (in death)	Due to (	or as a consec	quence of):						
ZAGIIII		_	Sequentially list conditions,	b. — Due to (	or as a consec	wonee of						
p <sub>0</sub>	ısi	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D08 t0 (	or as a consec	tuerice or.						
be executed	ıl-trar	Examiner	that initiated events resulting in death) Last	c	or as a consec	uence of):						
wrequires that the death certificate be executed been signed by the attending physician and	buria	calE				,						
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certif	se a	Physician/Med	IF FEMALE:	23c. If yes, out	come of pregn	ancy				234 1	Date of deliv	(0.0)
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the d	ched	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno								
that	deta		Part II. Other significant conditions	contributing to de	ath but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use co	ontribute to	the cause of death?
law requires t	ld be	d by	Severe cardi	myonut	hy				1 □ Y	es 2 No	3 🗌 Pro	bably 44 Unknown
	shou	lete	Dementia	9.	U				24a. Was a	an 24i	o. Were aut	opsy findings available
he law	page 2	ompleted	Device I'm						autop perfor	sy med?	prior to co death?	ompletion of cause of
VICAL F ician: Th certificate	or, pa	Ö	25. Was case referred to medical					OC Diseased Do	1 ☐ Yes ath (Check only or		1 🗆 Yes	2   No
ding Physician: h. After this certific	rect	0 8	examiner?	Hospital:	npatient 2	ER/Outpatien	t 3 DOA Ott		dome 5 ☐ Resid		thor (Spec	(A)
P F	erai c	-	27. Manner of Death	28a. Date of	of Injury	28b. Time of	28c. Injui	ry at	28d. Describe h			(9)
The state of the s	un e	i i	1 ■Natural 5 □ Pending 2 □ Accident investigat		h, Day Year)	Injury	M 1	rk? Yes 2 □ No				
Attending or death.	by the	ifica	3 Suicide 6 Could not determine	280. Place	of Injury - At h	ome, farm, str	set, factory, office				nber or Rur	al Route Number,
a afte	2	Certification:	4 Nonticide	bullali	ng, etc. ( <i>Speci</i>	(y)			City or Tow	n, Siale)		
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys	completely filled in		29a. Certifier 1 Certifying I	hysician: To the	best of my kno	owledge, death	occurred at the ti	me, date and place	e, and due to the d	ause(s) and	manner as :	stated.
ha Hi n 24 he Fu	plete	edical	one) 2 Medical Ex	aminer: On the ba and manr		ation and/or in	restigation, in my o	ppinion, death occi	urred at the time, o	ate and plac	and due t	to the cause(s)
To t To t	COM	Σ	29b. Signature and title of certifier				29c. Licens			29d. Date sign		
,	\		Gleneen	Borle	ines		DYY	1377		6/5	-106	
10X	<i>i</i>		30. Name and address of person wh	o completed caus	e of death (Ite	m 23a) (Type,	Print)	_		,		
10	1		Deneen Bowlin	ms 71	1 Maria	len Cl	vice L	one, Ca	tonsvil	le, n	i an	21228
**	Sta		31. Date filed (Month, Day, Year)	32 A	egistrar's Sign	ature		ı				
Re	gistr	ar	JUN V ( Z	UUD A	BURGED A	5.	Sec.					

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician June 5, 9:21 a M 2006 William Thomas Bloom /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Pocomoke City 2430 Dividing Creek Rd Worcester Year Birthplace (State or Foreign Country) If Under 1 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1**X** M 2 ☐ F 75 Yrs. 218-26-9627 Director July 17,1930 Md Usual Residence of Decedent 10b. County 10d. Inside City Limits the Maryland 10a. State 10c. City, Town or Location Show other traumatic event, the Medical Examiner must be notified at Pocomoke City Md. Worcester 1 ☐ Yes 2X No Director 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 21851 USA 2430 Dividing Creek Rd. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: ð 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Automotive Repairman 12 yrs. if Health and Mental Hygi Item 27 is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Millard Bloom Gladys Hambelton 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2430 Dividing Creek Rd. Pocomoke City Md. 21851 Roberta Bloom spouse 20b. Place of Disposition (Name of cemetery, crematory or other place Gardens of Faith Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of the important: If its any injury or of any inj June 8, 1 Burial 2 □ Cremation 3 □ Removal from State Rossville 2006 4 ☐ Donation 5 ☐ Other (Specify) Sonnelly Funeral Home Of Dundalk 21. Signature of Funeral Service Licensee 7110 Sollers Point Rd. 23a. Part 1. Enter the disease, of complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** IZhe /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consecuence of) Examiner The law requires that the death certificate be executed as the burial-transit the attending physicien and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy jo Month Day Year 4 Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Hospital: 1 Inpatient Certification: To 1 🗌 Yes 2 No 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b Time of 27. Manner of Death 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) or A after 4 Homicide within 24 hours a ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) completely and manner stated 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier 30. Name and address of person who co 31. Date filed (Month, Day, Year) State JUN 0 7 2006 Registrar

13/00m

William

State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** Burleson 5 2006 11:45pM J. June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Perry Hall Baltimore 9804 Richlyn Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year January, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** <sup>ear</sup>1919 1 M 2 F 87 Yrs Director 212-32-0411 North Carolina Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other trsumstic event, the Madical Examinar must be notified at 1 ☐ Yes 2 XNo Directo White Marsh Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21162 USA Box 10503 Vincent Farm Lane death Funerai 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 💢 No Specify: <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic events." (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Florist 4 years Floral Designer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dorothy Cabe Coffee Treadway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie Meusel daughter 2112 Tred Avon Road, Essex, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State June 9, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Memorial 2006 MIddle River, MD. 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 21222 7110 Sollers Point Road, Dundalk, MD. P. 11. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner death certificate be executed ettending physicien and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 DEctopic pregnancy Month Day Year 5 Other (specify) 4☐Pregnant at time of death been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ۵ 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 2∐ No 1 ☐ Yes 2D No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 6 Sother (Specify) Supples Hospital: 2 NO Other: 4 Nursing Home 5 Residence ို 2 ER/Outpatient 3□ DOA 1 Tes 1 Inpatient this To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation death. М 1 Yes 2 No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or A within 24 hours efter To the Funeral Direct 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of of 29c. License number ned (Month, Day, Year, cause of death (Item 23a) Type, Print) 30 Name and address of person 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.-2. Date of Death Decedent's Name (First, Middle, Last) Day Year **Physician** /Medical 2006 City, Town, or Location of Death Eacility Name (If not institution, give street and number) 4c. County of Death 4b. Examiner 5. Social Security Number 214-16-5136 7. Age (In yrs. last birthday) Birthplace (State or Foreign **Funeral** Days Min. 1 M 2 □ F 16,191 16 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Worle traumatic event, the Madical Examinar must be notified at 1 Yes 2 □ No Director Maryland mor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 3 Items 23a On Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 D No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after cannot of Health and Mental Hygiene.
ant: if item 27 is marked other than "natural; or lessing yor other traumatic event, in a Macical Examinating ury or other traumatic event, in a Macical Examination. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) 18-Mother's Name (First, Middle, Maiden Sumame) Be Print) Care Kir 19b. Mailing Address (Street and Num er or Rural Route Number, City or Town, State, Zip Code) 10 627 N V 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Department of h
Important: If ite
eny injury or ot
once. cemetery, crematory or other place, 1 M Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Son prest 21. Signature of Funeral Service Licenses 22. Name and Address Home Part | Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheps, or heart tabure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) METASTATIC COLON CARCINOMA vears /Medical Due to (or as a consequence of) Examiner S-quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 certificete 1 Yes 2No director, 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 X DOA 1 🗌 Yes 20 No 1 Inpatient 2 ER/Outpatient funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical ro the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Khuy Cles mD 22648 JUNE 5, 2006

State Registrar 31. Date filed (Month, Day, Year)

D

DHMH 17 Rev 1/2001

Slock Well, Wallace

ORIGINAL

JEROME I SNYDER m.D. 400 SOUTH CATON AVENDE BATIMORE MARYLAND 21229

me and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or AMEND State o rint in Black Indelible Ink. Ensure All Copies Are Legible. TEM#20b, PER FH, G857, 776706 WS Maryland / Department of Health and Mental Hygiene Registra Amend #10e&f Per FH G856 6/13/08/ifigate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year 17, 2006 4c. County of Death Month **Physician** 04:57 AM rnadna /Medical 4b. City, Town, or Location or Local...

South Local Litter 24 Hrs. 8 Pate of Birth Month, Day, Port, Lay. 4a. Facility Name (If not institution, give street and number) Examiner Ba pital of Baltimare Sinon Hos 5. Social Security Number 7. Age (In yrs. last birthday)
Yrs. Birthplace (State or Foreign Country) 6. Sex **Funeral** 1**X** M 2□ F 577-56-788) Usual Residence of Decedent Director Luk 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exeminer must be notified at Maryland 1 XYes 2 □ No Funeral Director mor 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ŏ 238 4601 Pall Mall Rd. 21215 12. Was Decedent Ever in U.S. Armed Forces? rit. Pages 1 and 2 should be filed within 72 hours after dee settment of Health and Mental Hygiene. crant: If Item 27 is marked other than "natural; or items rejury or other traumatic event, the Medical Examinator. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Race -1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: \$ 3 Widowed 4 Divorced lac unk Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 unk unt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unk 19a. Informant's Name/Relationship (Type, Print) (Social 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Metro Plaza a 17. 2/21 Srenc Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Slate 1 Burial 2 Cremation 3 Removal from State 6/12/2006 4 ☐ Donation 5 ☐ Other (Specify) arme permit.
Depertin 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
JOSeth
12222 W. North Ave. 8000 Funeral H ve. Balto. 23a. Par 1 Enter the distase, or complications that shuck, or heart failure. List only one cause on ns that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onset and Death Immedian Cause (Final disease or condition resulting in death) MULTISYSTEM Physician OR6-AN DAY FAILURE /Medical Due to (or as a consequence of): Examiner PSIS SE 3 DAVS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner transit ELFORATED INTRA-ABFONTNAL VISC end Due to (or as a consequence of): use as the burial-Box 68760 physicien certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ₫ in the past 12 months? Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Ś 2 NO 1 🗌 Yes 3 Probably 4 Unknown page 2 should Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed; this certificate 1 ☐ Yes Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Inpatient 1 Yes 2 ER/Outpatient 3 DOA After thi 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 5 Pending investigation death. 1 Yes 2 No within 24 hours efter death To the Funeral Director: 2 Accident completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide ŏ Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai ۽ 29b. Signature and little of certifies 29c. License number 29d. Date signed (Month, Day, Year) RES -000 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21287 ERICS, WEISS POBOX 110 TOWER 600 NORTH WOIFE STREET BALTIMORE MARYLAND M.P. 31. Date filed (Month, Day, Year) State Registrar JUN 0 7 2006

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 4/14 Betty Louise Carnea1 Tune 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harbor Hospital Baltimore n/a If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year, July 9, 19 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 PA **Funeral** 1□ M 2 F Yrs Director 217-20-0074 80 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: If Item 27 ie marked other than "natural", or Iteme 23a or 28a-1 ehow ary or other traumatic event, the Madical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Hygiene. other than "natural", or lieme 23a or 28a-f ehow ent, the Medical Examinar must be notified at 1 ☐Yes 2 ☐ No Completed by Funeral Director Maryland n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 705 Pontiac Ave 21225 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 years College (1-4or 5+) n/a Waitress Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosco Ebersole Belle Parks ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gilbert D. Carneal (HUsband) 705 Pontiac Ave. Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. Tyrone Grand View Cem 6-8-2006 Tyrone, PA 4 ☐ Donation 5 ☐ Other (Specify) McCully-Polyniak Funeral Home. P.A. 237 E. Patapsco Ave. Baltimore, MD 21225 unaral Service Licensee J. Wayne Osterling 23a. Part1. Enter shock, or he enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIAC dysichythmia /Medical Due to (or as a consequence of): Examiner ticemia Sequentially list conditions, I any, leading to initial diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Dusto (\*r as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transit URINALT TrAC Due to (or as a consequence of) P.O. Box 68760. RIGHT HIP IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery cate has been signed by the atter page 2 should be detached for u 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 res 2 No 1 ☐ Inpatient 2 → R/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Subject fell 1 ☐ Yes 2 X No 51512006 4:00 AM 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 705 Pontige Aul. Baltimore, MD 4 Homicide A+ home o the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dev. Year) D0061438 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) BUKOV 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar JUN 0

			Please	e Type or Print				=	_	le.	
			For State Registrar	State of Mai		rtificate of			g. No.2	16 1788:	
	sicia edica		1. Decedent's Name (First, Middle, I	-				2. Date of Death Month JUNE 4	Day Y	3. Time of Death 11:45P M	
	mine		4a. Facility Name (If not institution, g	· .		4b. City, Town,	or Location of Death	l	4c. County of	Death	
			STELLA MARIS			TIMC	NIUM If Under 24 Hrs.	10.5		rimore	
Fune Direc		}	5. Social Security Number 217 – 20 – 6538  Usual Residence of Decedent		(In yrs. last birthday) 96 Yrs.	Months Days		8. Date of Birth (Month, Day, 08/01/	Year) 1909 I	B. Birthplace (State or Foreign Country) PENNSYLVANI	
death with the Maryland ms 23a or 28a-f ehow		ctor	10a. State 10b. County BALT3		10c. City, Town or Lo LANNS					10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
th with th	1	al Director	10e. Street and Number 4230 HOLLINS	FERRY RD,	APT. 21	10f. Zip Code 2	1227	10	g. Citizen of Wh.	at Country?	
ING X IX I 3-0030  be filed within 72 hours after death with the Maryla Ital Hygiene Ital Hygiene And other then "naturet," or items 23a or 28a-1 show		by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: WHITE		
within 72 hours after ene."		Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	(Give	DO NOT use retire	during most of work	king	6b. Kind of Busin		
filed with		000	12TH		SI	NGER			ENTERT <i>A</i>	AINMENT	
should be file and Mental Hy		lo Be (	17. Father's Name (First, Middle, Last)  EUGENE WALSINGHAM  18. Mother's Name (First, Middle, Maiden Surname)  EBBA BERRGREM								
MG 2 In a 27 In a 127			19a. Informant's Name/Relationship DEBORAH ROMANO			-				ate, Zip Code) 21210 BALTO, MD	
of Head			20a. Method of Disposition 1 □ Burial 2 X Cremation 3	□Pomoval from State	20b. Place of Dispo	sition (Name of natory or other pla	ce)	Date 2	Oc. Location - Ci	ty or Town, State	
mit. Peges partment of portant: If It			4 □ Donation 5 □ Other (Spec		METRO C	REMATOR	Y 6/6,	/06	CATONSV	VILLE, MD	
Daltimor permit. Peges Department of Important: If It	og o		21. Signature of Eneral Service Lice	en A du			ess of Facility H(			HOME 21207 TIMORE, MD	
			23a. P. (rt. Pinter the disease, or co shock, or heart allure. List on Immediate Cause (Final	mplications that caused the control of the cause on each line	death. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death	
Physici /Medic Examin	cal		diseas or condition resulting in death)	a. <b>DEMENTTA</b> Due to (or as a	consequence of):				-		
f <sub>e</sub>		ner	Sequentially list conditions, if any, leading to immediate causa Enter Unorty a Cause (Disease or injury							·	
te be executed ysicien and be burial-transit		cal Examine	Cause (bisease or injury that initiated events resulting in death) Last								
certificat nding phy		/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date o	of delivery	
the death y the atte		Physician/medic	in the past 12 months? 1 ☐ Yes 2 <b>X</b> No 9 ☐ Unknown	1□Live birth 2 4□Pregnant at tir 9□Unknown		Ectopic pregnanc Other (specify) _	y		Month	*	
wrequires that the death certificate been signed by the attending physishould be detached for use as the		2	Part II. Other significant conditions	contributing to death but	not resulting in the ur	nderlying cause gr	ven in Part I.		acco use contribu	ute to the cause of death?  Probably 4 X Unknown	
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic monelety filled in by the funeral director, page 2 should be detached for use as the		Сотріете						24a. Was an autopsy perform	ed? prio	re autopsy findings available r to completion of cause of th? Yes 2 □ No	
VII.C ician ician ector		e C	25. Was case referred to medical examiner?	Hospital:		104		h (Check only one			
ng Phys		on: no	1 ☐ Yes 2 📉 No  27. Manner of Death  1 🌠 Natural 5 ☐ Pending	1 ☐ Inpatient 28a. Date of Injury (Month, Day )		1 3LJ DOA		ome 5 Resider 28d. Describe how		(Specify) HOSPICE	
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral in completely filled in by the funeral in the students.		Certification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide	be 28e. Place of Injury	- At home, farm, stre		Yes 2 □No	28f. Location (Stre	eet and Number o	or Rural Route Number,	
spital or ours afte				building, etc.		occurred at the til	me, date and place	City or Town,		or as stated	
the Hornin 24 h		Medical	(Check only 2 Medical Ex-	aminer: On the basis of each manner state	xamination and/or inv	estigation, in my o	ppinion, death occur	red at the time, da	e and place, and	due to the cause(s)	
7 3 5			29b. Signature and title of certifier	1		29c. Licens	17725		d. Date signed (M	Month, Dey, Year)	
7			30. Name and address of person wh		th (Item 23a) (Type, I	,	TIMONIUM,	MD 21093			
	State istra		31. Date filed (Month, Day, Year)  JUN 0 7 2006	32. Registrar's							
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City Town, or Location of Death Examiner Anne Arundel Glen Burnie Baltimore Washington Hospital Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral Birthplace (State or Foreign Country) Days 1 □ M 2 □ F Yrs. Director 212-18-4032 102 Dec 3, 1903 Maryland Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1698 Bayside Beach Drive 21122 U.S.A. itema 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after inent of Heelth and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Ite 1 Yes 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Completed by Specify Black 3 □ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Royal Lumber Company **Heavy Equipment Operator** 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Emma Carroll William Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Heetth a important: if item 27 is any injury or other tra: once. 1698 Bayside Beach Drive Pasadena, Md James Carroll 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 06/09/06 Pasadena, Md. 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Church Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final + readensine **Physician** ardiovasi disease or condition resulting in death) /Medical w as a consequence of) Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): The law requires that the death certificate be executed attending physicien end for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 (un un Completed 2  $\square$  No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? (es 2 No certificete 2 No 1 ☐ Yes 1 Yes or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Certification: To 2 X No 2 ER/Outpatient 3 □ DOA 1 Inpatient this After thi 28a. Date of Injury (Month, Day Year) Manner of Death 2 b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: , completely filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical

State Registrar

29b. Signature a

30. Name and addr

) Drae

31. Date filed (Month, Day, Year)

title of certifier

K16

2006

Jarro

ier

who completed cause of death (Item 23a) (Type, Print)

419

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Josephine B. Comberiate June 1, 2006 3:11 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13973 Clarksville Pike Highland Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 11, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1□M 2√XF Hours 1917 Washington DC Months 89 215 46 1760 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "netural", or iteme 23s or 28s-f show the Medical Exerciser must be collified at 1 ☐ Yes 2√☐ No Director Maryland Howard Highland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13973 Clarksville Pike 20777 United States death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Yes 2 TrNo If Yes, Give A.A. Year or Dates: 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 Mo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hyglene. Elementary/Secondary (0-12) College (3-4or 5+) Composer Music permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if Item 27 is marked other any Injury or other traument. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Antonio Oreste Bertolini Catherine Mary Gardella 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony Comberiate (SON) 7202 Meadow Wood Way, Clarksville, MD 21029 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) June 5, Date 2006 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Brentwood, Malryland Fort Lincoln Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servi 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) Physician Bladder CANCER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (ciscass or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Records, P.O. Box 68760. attending physician Physician/Medical as the l IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) the be detached 9 Unknown 9 Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy 2 No 1 ☐ Yes Division of Vital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of Injury 27. Manner of Death 1 Natural 2 ☐ Accident in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation death. 1 ☐ Yes 2 ☐ No s after death. 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide within 24 hours a Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) June2, 2006 39190 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Carrett Reilly, MD 3418 Olandwood Court, Olney, MD 20832 32. Resstrar's Signature State 2006 Perfects. Registrar

		1 - For State Registrar	State of M	farylan				ealth an Death			Reg. No	40	06	Management	788
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Physician /Medical Examiner prize pr	icai Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. A3 D	s a consequence of a co	uence of:	e à	ne	UM\	on	la				nterval B Ponset and B h h d v	
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To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medicai C	29a. Certifier t Certifying P (Check only one)	hysician: To the bes miner: On the basis and manners	of examinat	wledge, deat tion and/or in	h occurred vestigation	at the tim	ne, date and p pinion, death (	olace, an	d due to the d at the time,	cause(s) date and	and mand place, an	ner as stat d due to t	ed. he cause	r(s)
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10		30. Name and address of person who	ri 1	601	EAS	Print)	ELV	ED EXE	3 F	WE	BH	200	M	3	1339
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 06 JINA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Continuum Care Sykesville 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 NC 7. Age (In yrs. last birthday) 6 Sex **Funeral** Hours 1 ☐ M 2 X F 545-30-9290 96 Yrs 1909 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at Yes 2 No MD Director Carrol1 Sykesville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a or 7309 Second Avenue 21784 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. I mportant: if Item 27 is marked other than "natural; or Item any injury or other traumatic about Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√∑ No Specify: Specify: þ White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Calhoun Smith 0 Althea Reynolds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Bill Muncy (Son) 9 Freeport Lane Ocean Pines, MD 21811-3804 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State All County Cremation 6/7/2006 \* 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL, P.A. (Box 195) L. Halso Sykesville, MD 21/84 (410)-795-1400 23a. Part1. Enter the disease, or complications the I caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Dua to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 □Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan after death.

Director: After this certificate has 20 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 ™o 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 🔲 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 \( \) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 \( \) Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006 DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene) For State Registrar Amend Item #18 Per FH G856 6994766 at The Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Madalyn A. Capes 2006 3:15p June 4 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Copper Ridge Sykesville If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕶 F 83 292-18-7038 Vrs May 4 1923 OHIO Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show other traumatic event, the Medical Examiner must be notified at Carroll Svkesville 1 X Yes 2 No Md Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21784 USA 710 Obrecht Road or Items 23a death v 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mentai Hygiene. Important: If item 27 is marked other than "natural", or Iten any injury or other traumatic event, Ite Medical Examinat 1 □ Yes 2 □ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo þ Specify: white 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Martha Kursten Kerstien Paul Scheuffler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leah C. Mazade (daughter) 11313 Rokeby Ave. Box 333, Garrett Park, Md 20896 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State
4 Donation 5 Other (Specify) All County Cremation 6-7-06 Sykesville, Md 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Dage Haight Sterbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) week Pheumoma Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year for Month Day 1 U Yes 2 No 9 Unknown in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed by table and the sign of the sign o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Sylenosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 🗆 No 1 ☐ Yes 2 No To the Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tyle 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eldersburg MD 21794 Road TAN MO 1645 William 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 0 7 2006

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 5<sup>Day</sup> June 2008 3:45 Angelo Louis Coluzzi 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Stella Maris Timonium Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Feb 2 1, 5. Social Security Number Birthplace (State or Foreign Country)
 Mary land 6. Sax 7. Age (In yrs. last birthday) 1914 1 M 2 ☐ F 92 213-09-9970 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Cockeysville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21030 USA 10707 Cardington Way Apt T4 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status 1 Never Married 2 Married 1 Tes 2 No Specify Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Purchasing Agent Bendix Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margarette Salvo Louis Coluzzi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) / wife 10707 Cardington Way Apt T4; Cockeysville, MD 21030 Evelyn R. Coluzzi 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🐼 Other (Specify) entonoment Dulaney Valley Mem Gardens 6/7/06 Timonium, MD 21. Signature of Furjeral Service Donse 1050 York Road 22. Name and Address of Facility etul Towson, MD 21204 Ruck Towson Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition CHRONIC OBSTRUCTED PULMONARY DISEASE resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death | Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No HOSPICE 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🔣 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) liest Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

use as the burial-tran attending physician for use as the buria P.0. signed by Records, has this certificate of Vital death. Funerei

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page 2 should nerei Director: A To the within 2

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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item 27 la

Physician

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Certification: To

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Pages 1 and 2 should be nent of Health and Mental

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death with the Maryland

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Maryland

Baltimore,

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JUNE

State Registrar

DHMH 17 Rev 1/2001

DR. IANAS 31. Date filed (Month, Day, Year) .!UN 0 7 2006 DR. TARIQ MAHMOOD

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD. 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🙎 🛛 🖺 🔓 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yeer **Physician** CRAWFORD MARIE 2 2006 1422 /Medical JUNE 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A Kins he Johns Ho HOSPITA . Age (In yrs. last birthday)
52 Yrs. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth
Jan 29ay, Y1954 9. Birthplece (State or Foreign **Funeral** 1□M 2**X**F Hours Davs 213-66-9701 Maryrand Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Exercises number by notified at Md. **Baltimore** Hunt Valley Director 1 Yes 2K No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itams 23a or 12328 Michaelsford Road 21030 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Specify þ White 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then 'eny injury or other fraumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lillian Warfield Paul E. Walega, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12328 Michaelsford Rd. Hunt Valley, Md. 21030 Mr. Reagan Crawford/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Hilltop Service Co. 6-5-06 Towson, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Frankral Service Licenses <sup>22</sup>Ruck<sup>an</sup> Towson Filmeral Home, 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** one dan Sensis disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner manthe Graff versus host Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit death certificate be executed Kone Marrow Transla Due to (or as a consequence of): Physician/Medical Myelodysplen two years IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 4 Pregnant at time of death the detached 1 Yes 2 No 9□ Unknown 9 Unknown ģ s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an page certificate 1 Yes 2 □ No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Yeer) 27. Magner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: / completely filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and tale of certifie 29c. License number 29d. Date signed (Month, Day, Year) MO RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

GARIBALOI

31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

P.O. Box 68760,

Division of Vital Records,

600 North Volle Street Builting Maryland 21287

The John, Hopkins Hospital

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day KATHRYN C. CIVISH 2006 7:15A M lune /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death KESWICK MULTI-CARE BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 08/24/1914 MARYLAND 1 ☐ M 2 💢 F 215-48-6096 91 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or Iteme 23a or 28a-f show 10d. Inside City Limits traumatic ayent, the Medical Examiner must be notified at Director MD 1 Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 WEST 40TH STREET 21211 USA death Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No þ If Yes, Give Year or Dates: Specify: Specify: 3 Widowed 4 □ Divorced WHITE natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) HOUSEWIFE HOMEMAKER 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fill Department of Health and Mental Hy Important: If Item 27 ie markad oth any Injury or other traumatic avent 18. Mother's Name (First, Middle, Maiden Sumame) Be FRANK CHAMBERS GENEVIEVE BOONE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) REX LENDERMAN (ATTORNEY) 606 BALTIMORE AVE. TOWSON, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State LOUDON PARK 06/08/2006 BALTO. MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W. JENKINS & SONS O YORK RD MONKTON, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of) anding physicien and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy ģ Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe certificate 1 Yes 2 1 No in by the funeral director, To Be 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Dath Check only one Hospital: 1 Inpatient Other: 4 Jursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this 27. Mann Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred After 1 Matural 5 Pending investigation within 24 hours efter death. To the Funeral Director: A 1 Tyes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: Un the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Halle egge 77) D13657 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TACHREGOR 40 K STREET, BALTIMORE, OD SIXII M. ISMBELLE 700 W 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 7 Registrar

	Please	Type or P	rint in Black In	delible lnk. Ensu	re All Cop	ies Are	Legible.			
				artment of Health a	-			1789	2	
For State Registrar		Giate of		rtificate of Death		Reg. No		1 1 0 3	Even	
Decedent's Name	e (First, Middle, La:	st)			2. Date of			3. Time of Deat	h	
NATALIE			С	CHAZEN	JUNE	5	′ 200 <sup>°</sup> 6°′	3:05P	М	
Facility Name (I	f not institution, giv	e street and num	ber)	4b. City, Town, or Location of	of Death	4c.	County of Death	1		
RUXTON PIKESVILLE NURSING HOME PIKESVILLE BALTIMORE										
Social Security N 212–42–		ex 7 □ M 2 □ F	7. Age (In yrs. last birthday)	If Under 1 Year If Under Months Days Hours		of Birth h, Day, Year) 5/1929	9. Birth	mplace (State or Ford MD	eign	
ual Residence of	Decedent									
a. State	10b. County		10c. City, Town or Lo					10d. Inside City Lin		
MD	BALT	IMORE	BALTI	MORE				1 □ Yes 2 🛣	No	
e. Street and Nur	mber			10f. Zip Code		10g. Cit	zen of What Cou	untry?		
7 SUDBRO	OOK LANE			21208			U.S.A.			
Marital Status		12. Was Deced	lent Ever in U.S. 13.	Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican	gin? (Specify Yes	or No-	14. Race - American Indian,			
1 Never Marri	ied 2 Married	1 ☐ Yes 2	2 🐧 No		)	Black, White, etc.				
3 X Widowed	4 □Divorced	If Yes, Give Year or Dat		1 ☐ Yes 2 No Specify:			Specify: WHITE			

SECRETARY

16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired)

18. Mother's Name (First, Middle, Maiden Surname)

16b. Kind of Business/Industry

CITY OF BALTIMORE

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "netural; or iteme 23a or 28a-f show empt highery or other traumatic event, the Madical Examinat must be notified at once. Baltimore, Maryland 21215-0036

Physician

/Medical

**Examiner** 

**Funeral** 

Director

NATALIE

RUXTON 5. Social Security

4a. Facility Name

Usual Residence

10e. Street and N

11. Marital Status

15. Decedent's Education city only highest grade completed)

Cottege (1-4or 5+)

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

10a. State MD

Completed by Funeral Director

**Physicia** /Medic Examin

within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

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ALBERT		COHEN	BERTHA	J P	JNOBKAINABLE	
19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailing Address (Street	et and Number or Ru	ıral Route Number, (	City or Town, State, Zip Code	9)
SHELDON CHAZEN / S	SON	713 SUDBROOM	K ROAD - E	BALTIMORE.	MD 21208	
20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State HI	Place of Disposition (Name of cemetery, crematory or other pl			TOWSON, MD	State
21. Signature of Funeral Service Licenses	dth	22. Name and Add	. 20		N & BROS., II KESVILLE, MD	NC. 21208
23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the dea				t. App	roximate rval Between
Immediate Cause (Final disease or condition		son's Disea	Se			et and Death
resulting in death)	Due to (or as a conse	equence of):				
Sequentially list conditions, b.	Due to for as a conse					
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that initiated events c. resulting in death) Last	Due to (or as a conse	aquence of):				
d.						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 Ectopic pregnan			23d. Date of delivery Month Day	Year
Part II. Other significant conditions cont	inbuting to death but not re	sulting in the underlying cause g	iven in Part I.		cco use contribute to the car	
Add to the first terms of the fi				24a. Was an autopsy performe		ion of cause of
25. Was case referred to medical examiner?			26. Place of Dea	ath (Check only one)		
1 □ Yes 2 ☑ No Ho	ospital: 1 Inpatient 2	□ ER/Outpatient 3□ DOA O	ther: 4 Nursing H	lome 5 Residence	ce 6 □Other (Specify)	
27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)			28d. Describe how		
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, street, factory, office cify)	)	28f. Location (Stre City or Town,	et and Number or Rural Rou State)	te Number,
29a. Certifier 1 Certifying Physic (Check only one)	ician: To the best of my kner: On the basis of examinand manner stated.	nowledge, death occurred at the nation and/or investigation, in my	time, date and place opinion, death occu	, and due to the cau irred at the time, date	se(s) and manner as stated. a and place, and due to the o	cause(s)
29b. Signature and title of certifier		29c. Licer	nse number	29d	. Date signed (Month, Day,	Year)
Danie & B	Brown DI M. I	D.O4	258676	-31	100 1 2006	

DHMH 17 Rev 1/2001

State Registrar 25 main street

32. distrar's Signatur

54, te 200,

Reisters town

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Babitt

31. Date filed (Month, Day, Year)

			1 - State of Maryland / Department of Health and Certificate of Death	Mental Hy	giene 006	17893
	Physic /Medi		1. Decedent's Name (First, Middle, Last)  Patricia (ampbell	2. Date of Do Month May	Day Year	3. Time of Death
7	Exami		4a, Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Deat  ADRICH BALLING		4c. County of Deat	h
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Bi	9. Birth	hplace (State or Foreign untry)
	iryland ihow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	th the Ma or 28a-f	irecto	MD 10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	1 XYes 2 □ No untry?
	death wil	eral D	48 27 Green Crest Road 2/206  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	Specify Yes or No	USA 14. Race - Ame	ncan Indian
9036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If itsm 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	d by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1  Never Married	to Rican, etc.)	Specify:	lack
21215-0036	within 72 h ene. than "natu he Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Element (Specify only highest grade completed)  College (1-4or 5+)	rking	16b. Kind of Business/	Industry
	2 should be filed withir and Mental Hygiene. Is marked other than surmatic event, the Ms	Be Cor		ne (First, Middle	, Maiden Surname)	pphus
Maryland	should to	To	Walter Hester  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru	A Sace		ip Code)
_	s 1 and 2 of Health a itsm 27 is		CENEVA Hester (Mother) 4827 Green Crest 20a. Method of Disposition (Name of	PRd, I	Balto MD	21206 Town, State
Baltimore,	Fa Fa Fa		(10) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	6/4/0	Balto	MD.
Ba	permit. Departr Imports any Inju		I lun W. him Vaugh Corter	petu	to MD 213	ias
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyill 3, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition and the condition as a such as	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	200		w years
11	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
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Box 68	eath certificate attending phys I for use as the	n/Medi	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delin	
o.	The law requires that the death certific sie hes been signed by the attending p age 2 should be detached for use as	Physician/Me	in the past 12 months?  1		Month	Day Year
ds, P.	uires that signed t	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute to	the cause of death?
ecor	a law requ hes been e 2 shoul	Completed		24a. Was	an 24b. Were aut	opsy findings available ompletion of cause of
ital F		Be Cor	25. Was case referred to medical examiner? 26. Place of Deal	perfo	rmer? death? 2 No 1 Yes	
of \	Physician: ar this certific eral director,	မှ	Yes 2 □ No Hospital: 1 □ Inpatient ★ER/Outpatient 3 □ DOA Other: 4 □ Nursing Ho	ome 5 ☐ Resid	dence 6 Other (Speci	(y)
Division of Vital Records,	Attending F r death. ector: After by the funera	Certification:	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation 3 Suicide 6 Could not be			
Ö	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th		building, etc. (Specify)	City or Tow		
	the Hos hin 24 ho the Fun mpletely	Medical	(Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	rred at the time,	date and place, and due t	o the cause(s)
)	5 With C		29b. Signature and title of certifier  29c. License number  D18667		June 1,2	
	d		30 Name and address of person who completed cause oddeath (Item 23a) (Type, Print)  Philip Militella, MI. 6 Trumble Hill CT. Lutho	nuille	Tyne 1,2 ,MD 210	93
	Sta Registr	te ar	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
DHM	/IH 17 Rev 1/20	001	ORIGINAL			

			pe or Print in Black in State of Maryland / Dep		•	•	
		1 _ State		rtificate of Death		2006	17891
		Registrar  1. Decedent's Name (First, Middle, Last)		Timoato of Bouin	2. Date of Deatl	ng. No.C UUU	3. Time of Death
Physic		Dorothy	Mae	Dent	Month	31 2006	4:15 a <sup>M</sup>
/Med Exami		4a. Facility Name (If not institution, give stre		4b. City, Town, or Location of Death		4c. County of Death	
Exam	nei	3387 Malcolm Road	i	Brandywine		Charles	
Funera		Social Security Number     6. Sex	7. Age (In yrs. last birthday,		8. Date of Birth (Month, Day,	Year)931 9. Births	place (State or Foreign ntry)
Director		217-28-1973	<sup>2</sup> X <sup>f</sup> 74 Yrs.		August	27, Mar	yland
and **		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
Manyl f sho	٥	Maryland Charles	Brandyw	ino			Yes 2 No
the 1	Director	Maryland Charles  10e. Street and Number	Drandyw	10f, Zip Code	10	Og. Citizen of What Cour	ntry?
3a or	O O	3387 Malcolm Roa	ď	20613		USA	
deatl	Funeral	11. Marital Status 12.	Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No-	14. Race - Americ Black, White,	can Indian,
after a	/Fu		1 ☐ Yes ② No If Yes, Give	1 ☐ Yes 2 XNo Specify:		Specific	
5-0036 72 hours at natural; or	d by	3x Widowed 4 □ Divorced	Year or Dates:			BI	ack
1215-0036 within 72 hours after death with the Maryland ene. than "natural" or flems 23a or 28a-f show the Modeal Exeminer reast be multified at	Completed	15. Decedent's Educat (Specify only highest grade c	ompleted) (Give	edent's Usual Occupation a kind of work done during most of wor DO NOT use retired)	king	16b. Kind of Business/In	dustry
with and the state of the state	l mo	Elementary/Secondary (0-12)	College (1-4or 5+)	nselor		Spring De	ll Center
other	BeC	17. Father's Name (First, Middle, Last)			ne (First, Middle, N		
lar lar	10 B	Layton	Johnson	Charlo	tte	Me	cPherson
Maryland 2121. d 2 should be filed within th and Mental Hygiene. ?? Is marked other than "traumatic event, the Mas	1	19a. Informant's Name/Relationship (Type	Print) 19b. Mail	ing Address (Street and Number or Ru	ral Route Number,	City or Town, State, Zip	Code)
and and ealth m 27		Marilyn Johnson/D		Malcolm Rd Bra			
altimore, mit. Pages 1 ar partment of Hea portent: If Item: y injury or other		20a. Method of Disposition 1 ⇒Burial 2 □ Cremation 3 □ Rem	20b. Place of Disp cemetery, cre	osition (Name of ematory or other place)	Date	20c. Location - City or To	own, State
timen timen tent:		`4 ☐Donation 5 ☐ Other (Specify)	St. Pet	er <u> </u> 6/0!	5/2006 1	Maldorf, Ma	aryland
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Madical Enseminar reast be rightlied at nones.		21. Signature of Funeral Service Licenses	101 3	2. Name and Address of Facility Add	ams Fune	eral Home	PA
		23a. Part . Enter the disease, or complica shock, or head killure. List only one		0605 Aquasco Ri			Approximate
Dharista		Immediate Cause Final					Interval Between Onset and Death
Physician /Medica	_	disease or condition resulting in death)	Due to (or as a consequence of):	LUMA DISE			
Examine		Securetially lies conditions					
70 #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
and	Examiner	that initiated events c resulting in death) Last	Due to (or as a consequence of):				
Box 68760, 37 eath certificate be executed attending physician and for use as the burial-transit	E III		5 to (o. as 2 to				
Records, P.O. Box 687 The law requires that the death certificate the has been signed by the attending phys age 2 should be detached for use as the		d					
Box (and the sattle a	Physician/Medic	IF FEMALE: 23c. Was decedent pregnant	If yes, outcome of pregnancy 1□Live birth 2□Fetal death 31	□Ectopic pregnancy		23d. Date of delive	ery
Cords, P.O. Box wrequires that the death cer been signed by the attendir should be detached for use	sicia	in the past 12 months?		Other (specify)		Month	Day Year
P.O.	Phys	9 Unknown			00.01111		
S, res th	b	Part II. Other significant conditions contri	buting to death but not resulting in the t	underlying cause given in Part I.		acco use contribute lo ti s 2 □ No 3 □ Prot	
Vital Records, sicien: The law requires to certificate has been signer rector, page 2 should be to	Completed						
Rec	mpi				24a. Was ar autopsy perforg	y prior to co	opsy findings available impletion of cause of
Vital F vician: Th certificate rector, pag		25 M/s referred to readical			1 ☐ Yes 2	No 1 ☐ Yes	2 No
ysicial ysicial is certi	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	pital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Other	th (Check only one	nce 6 □Other (Specif	6/1
on of ding Phy h. Atter this funeral o	n: To	27. Manner of Death	28a. Date of Injury 28b. Time of		28d. D scribe ho		,,
Division of Vital to Attending Physician: after death. Director: Atter this certification by the funeral director.	atio	1 Natural 5 Pending 2 Naccident investigation	(Month, Day Year) Injury	M 1 Yes 2 No			
Division Attendate death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office	28f. Location (Str. City or Town	reet and Number or Rura , State)	al Route Number,
Ultel o							
Division of Vital Re To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: Alter this certificate he completely filled in by the funeral director, page	edical		ian: To the best of my knowledge, dea :: On the basis of examination and/or in				
o the ithin 2 o the	Mec	29b. Signature and title of certifier	and manner stated.	29c. License number	29	d. Date signed (Month,	Day, Year)
F 8 F 00		1 Koise M	Kathen	D2A57		5/31/06	
2		30. Name and address of person who com	bleted cause of death (Item 23a) (Type	, Print)		,	
3	ŀ	PO Box	1703 LaP	lata mo	2064	6 .	
	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signature				
Regis	trar	JUN 0 7 2006	Breuze H. A.	and a second			

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of I	Maryland		artment of tificate o				iene eg. No.	000	5 17	895
			Decedent's Name (First, Middle, La	st)	_				2	. Date of Dear	th Day	Year	3. Time of E	Death
	Physici /Medic		Robert L	inton Da	alton					June		006	2:28pm	M M
ķ	Examin		4a. Facility Name (If not institution, giv	e street and numb	er)		4b. City, Town	, or Location	of Death		4c. Count	y of Death	1	
			Fairhaven Healt					cesvill				Carr		
	Funeral		5. Social Security Number 6. S	ex 7. □M 2□F	Age (In yrs. las	t birthday) Yrs.	If Under 1 Ye Months Day		Min.	. Date of Birth (Month, Day	Year)	9. Birth	place (State or intry)	Foreign
	Director		216-05-8254 Usual Residence of Decedent	X	86				J	une 22	, 1919		_MD	
	ow o		10a. State 10b. County		10c. City, 1	Town or Lo	cation						10d. Inside City	Limits
	Man	ţo	MD Carro	11		S	kesvil.	Le					1 ☐ Yes 2	2X No
	th the	irec	10e. Street and Number				10f. Zip Cod	Э		1	0g. Citizen of	What Cou	ıntry?	
	23a c	rai	7200 Third Aven					1784			USA			
	tems	Funeral Director	11. Marital Status	12. Was Decede Armed Force	es?	13.	Vas Decedent of f Yes, specify C	if Hispanic Ori uban, Mexicar	igin? (Speci n, Puerto Ri	fy Yes or No- can, etc.)		ce - Amer ick, White	ican Indian, , etc.	
36	s afte	by F	1 ☐ Never Married 2 📆 Married 3 ☐ Widowed 4 ☐ Divorced	M∏Yes 2 If Yes, Give Year or Date	□no s: WWII	г	□ Yes 211/1	lo Specify:			Specia	<sup>ʻy∷</sup> Wh	ite	
2-0036	d within 72 hours after death with the Maryland jene. r than "natural", or Items 23a or 28a-1 show the Medical Examinar must be maillied at	edt	15, Decedent's E			16a. Dece	lent's Usual Oc	cupation			16b. Kind of E			
215	n "ne	Completed	(Specify only highest grant (0-12)	college (1-4	or 5+)	(Give life. l	kind of work do OO NOT use ret	ne during mos ired)	t of working					
212		E O	Elementary/Secondary (5 12)	1	5, 5,7	Sul	station	n Worke	er		Electr	ic C	ompany	
덜	should be filed and Mental Hygin marked other matic avent,	Be (	17. Father's Name (First, Middle, Last					18. Mothe	er's Name (i	First, Middle, i	Maiden Sumai	ne)		
<u>X</u>	should bent marked	은	John Dalton							e Lin				
Maryland	2 2 2 2	. 3	19a. Informant's Name/Relationship (		1		g Address (Stre						p Code)	
	is 1 and of Health item 27 other to		Mrs. Eleanor Dal	con (Spou			Third A		Sykes		MD 217 20c. Location		own State	
ğ			1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from Sta	119		sition (Name of natory or other p	1				,		
altimore,	permit. Par Departmen Important: any injury pnce.		' 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice		All		y Crema			006	Sykesvi	.lle,	MD	
Ba	permit. Page Department of Important: If any injury or once.		Buan	Has	It	HA	IGHT FU kesvill	JNERAL	HOME .	& CHAPI	EL, P.A	(B	ox 195)	
			23a. Part1. Enter the disease, or com	plications that cau	ed the death.	Do not ent	er the mode of	tying, such as	cardiac or r	espiratory arr	est,	.00	Approximate Interval Between	een
	Physician	0 1	shock, or heart failure. List only Immediate Cause (Final	one cause on	ultin	£-	+ 1	+	7,				On the and De	eath
	/Medical		disease or condition resulting in death)	a. Due to (or	as a consequer	nce of):	1/4	Banks 6					(CZV)	2
	Examiner		Conventially list conditions	b										
. (	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a consequer	nce of):								
14	ecute and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c								_		
90,	be executed sician and burial-transit		1000tting in dozan, zast	Due to (or	as a conseque	rice or).								
8760,	ate hys	dical	•	_ d	-									
ox e	eath certific attending p for use as l	Physician/Me	IF FEMALE:	23c. If yes, outco	me of pregnanc	;y					23d. Da	ate of deliv	/erv	
ä	atter after of for u	clar	23b. Was decedent pregnant in the past 12 months?		n 2 ☐ Fetal de t at time of deal		Ectopic pregna Other <i>(specify,</i>					onth	Day Ye	ar
O.	the d by the ached	hysi	1 Yes 2 No 9 Unknown	9□ Unknow	n									
<u>.</u> ص	The law requires that the de site has been signed by the a page 2 should be detached f	by P	Part II. Other significant conditions	contributing to deat	h but not resulti	ing in the u	nderlying cause	given in Part I		23e. Did to	oacco use con	tribute to 1	the cause of dea	ath?
ğ	w require been sig should b									1 □ Ye	s 2 00	3 🗌 Pro	bably 4 ∐Un	known
Records,	aw re	plet								24a. Was a autops	n 24b.	Were auto	opsy findings av	ailable
Ĕ	: The law cate has l page 2 s	Completed								perform	ned?	death?		
Viital	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?						of Death (	Check only on	e)			
	Physic this ce	2	1 ☐ Yes 2 ☐ <b>1</b> €	Hospital: 1 ☐ Inp		R/Outpatier	t 3 DUA	- Aust	311		ence 6 Oth		ify)	
ב	ffer free ring	on:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of (Month,	njury 28 Day Year)	8b. Time of Injury		vork?		d. Describe ho	w injury occur	red		
<u>s</u>	Attendi death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be	e Ogo Blaco of	Injury - At home	a farm etr		☐Yes 2☐		f Location (St	reet and Numi	her or Rui	al Route Numbe	er
Division of	or Al after of Direction by	Certification;	4  Homicide determined	building	, etc. (Specify)	e, iaiiii, sti	set, lactory, offi	26		City or Town	n, State)	70, 0, 1,0,	4, 10010 112110	,
_	spital ours a neral filled		29a. Certifier 1 → Certifying P	nysicien: To the be	est of my knowle	edge, death	occurred at the	time, date ar	nd place, and	d due to the ca	ause(s) and m	anner as :	stated.	
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	(Check only 2 Medicel Exa	niner: On the basi and manner	s of examination stated.	n and/or in	estigation, in m	y opinion, dea	ith occurred	at the time, da	ate and place,	and due t	to the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifier	,			29c. Lice	ense number		2	9d. Date signe	of (Month.	Day, Year)	
)			1 Titles 4	1- MV.	7		1	3058	13-	2	6/	2/0	26	
	15		30. Name and address of person who	completed cause	of death (Item 2	За) (Туре,				nete		1	_	
	17		Willau Kus	245	stoner	Hue	St 30	1 W	10stan	nete	mil	21	157	
	Sta Registr		31. Date filed (Month, Day, Year)	82. Heg	istrar's Signatur	dine	(L)							
			JUN U 7 ZUUC	R. S. S. S. S. A.	1 10	Jana d								

			1- State of Maryland / Department of Healt Certificate of Dea		lygiene 2006	17895
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Ann Diamond	2. Date of the Month May	29, 2006	3. Time of Death
	Examir Funeral	ner	Months Days Hou	ac Cryy nder 24 Hrs. 8. Date of E urs Min. (Month.)	3irth 9. Birth Co	thplace (State or Foreign untry)
	Director		216-20-6753 87 Yrs.  Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	Apr 21	, 1919 Mary	10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show	ector	MD Baltimore  10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	1X Yes 2 □ No
	3a or	į	1120 Whitelock Street 21217		USA	untry
20036 00036		by Funeral Director	11. Marital Status  1 Never Married 2 Marned  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, 2 No If Yes, 2 No If Yes, 3 No Year or Dates:  1 Yes 2 No Specific No Specific No. Specific N			e, etc.
770M	filed within 72 hours after Hygiene. ther then "natural", or Ite int, the Medical Examilie	Be Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  unk  16a. Decedent's Usual Occupation (Give kind of work done during in life. DO NOT use retired)  If the DO NOT use retired)	поst of workingunk	16b. Kind of Business/	
and	d a b	To Be (		lother's Name <i>(First, Midd</i> Lvian Cook Br		
Mary	2 should and Men is marke	ľ	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Nu.	mber or Rural Route Num	ber, City or Town, State, 2	Zip Code)
Ann altimore, N	Pages 1 and 3 nent of Heaith ant: If Item 27 ury or other tr		Maryland General Hospital  20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  827 Linden Ave.  20b. Place of Disposition (Name of cemetery, crematory or other place)	Baltimore, M	MD 21201 20c. Location - City or	Town, State
Balt	permit. Pages Department of Important: If I eny injury or once.		21. Signature Funeral S. vice Licensee State Anatomy Baltimore, MD	Board 655 W	. Baltimore	Street
8760,	Physician /Medical Examiner was printed the burial-transit	ifcal Examiner	29a. Part) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, a heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that inditated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	pas cardiac or respiratory Lition Parlure		Approximate Interval Batween Onset and Death
Division of Vital Records, P.O. Box 6	Attending Physician: The law requires thet the death certifical rodath.  •ctor: Afler this certificate has been signed by the ettending phy by the funeral director, page 2 should be detached for use as th	Physiclan/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify) 9 Unknown		23d. Date of deli Month	ivery Day Year
rds, P	w requires thet been signed b should be deta	Ď	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa		d tobacco use contribute to ☐Yes 2☐No 3☐Pro	. /
al Reco	:: The law re cete has bei ; page 2 sho	Completed		per	topsy prior to death?	topsy findings available completion of cause of 2 No
Zit.	stcian: Th certificete irector, pag	o Be	examiner?	lace of Death (Check only		
ion of	nding Physician: The ath. r: After this certificete ha e funeral director, page	atlon: To	27. Manner of Death 1 Matural 5 Pending (Month, Day Year) 2 Accident investigation 1 Inpatient 2 ER/Outpatient 3 DoA 1 4 2 28a. Date of Injury (Month, Day Year) 3 DoA 1 2 28b. Time of Injury Work? 4 28b. Time of Injury Work? 1 Yes 2	28d. Describe	sidence 6 Other (Spece how injury occurred	(ny)
Divis	2 2 2 2	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28s. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location City or To	(Street and Number or Ruown, State)	ral Route Number,
	he Hospital in 24 hours e he Funerel E pletely filled i	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.	and place, and due to the death occurred at the time	e cause(s) and manner as a, date and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier  895  895		29d. Date signed (Month)	/
			30. Was and address of person who completed sause of death (Item 23a) (Type, Print)	Mand R	5/29/ Meral 40	sortal
	Sta	te	31. Date filed (Month, Day, Year)	1100 100 010	1 Max 140.	7
	Registr		JUN 6 7 2006			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Obent 1)abneu 2006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number 4c. County of Death Examiner Agnes 1+m one Hus If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 1 M 2 □ F Days Hours Z1Z-Z8-9986 Usual Residence of Decedent Yrs Aug Ust 1,1933 Director with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ₽ Yes 2 □ No Director Baltmore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21229 805 Funeral Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 12 No ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Driver 17. Father's Name (First, Middle, Last) Henry 2 19a. Informant's Name/Re tionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bultmone MO 21229 4305 Connecticut Avenue Shirley Dabney 20a. Method of Diss sition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □Other (Specify) 22. Name and Address of Far Har. P. CUS 21. Signature of Funeral Service License Below No al 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cayse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Carda Viscalar Dream **Physician** veav( disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification: To Be Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 1 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one! Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗹 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) funeral 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pendina within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Sutcide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Tame and address of pers to the completed cause of death (Item 23a) (Type, Print) Caton 900 32. Signature 31. Date filed (Month, Day, Year) State Registrar

JABNEY, ROBCR

			1 - For State Registrar		of Maryland			t of H	lealth a	and M			006	17898
	Physic	ian	1. Decedent's Name (First, Midd	fle, Last)							2. Date of Dea	ath Day	Year	3. Time of Death
	/Medi		VICTOR	M				DI	EITZ		JUNE	4 2	2006	12:57P <sup>™</sup>
7	Exami	ner	4a. Facility Name (If not institution	_	umber)		4b. City,	Town, or	Location of	of Death		4c. Co	unty of Death	3
			LEVINDALE HEBR		-			LIMOR						N/A
21	Funeral	6	5. Social Security Number 217-32-1806	6. Sex 1	7. Age (In yrs. last	t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours		8. Date of Birt	h ( Year)	9. Birth	place (State or Foreign
4	Director	0	Usual Residence of Decedent	X _	90	115.					03/08/1	916		MD
	laryland show		10a. State 10b. Count	/	10c. City, T	own or Lo	cation							10d. Inside City Limits
	the Maryla 28a-f shor	ō	MD B	ALTIMORE		BALTI	MORE							1 ☐ Yes 2X No
	r 28a-f	rec	10e. Street and Number		1		10f. Zip	Code				10a. Citizen	of What Cou	intry?
	death with the Maryland ms 23a or 28a-f show	Funeral Director	11 SLADE AVENU	F #712			21	.208					U.S.	•
	ter deat items	nera	11. Marital Status	12. Was Dec	cedent Ever in U.S.	13.			spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)	14.	Race - Amer	ican Indian.
9	or ite	F	1 ☐ Never Married 2 ☐ Ma	rned Armed F	orces? 2 ☐ No ive	1	1 Yes, spec 1 □ Y <i>e</i> s 2	V		n, Pu <i>er</i> to	Rican, etc.)		Black, White	, etc. HITE
5-0036	72 hours after naturel', or ite	d by	3 Widowed 4 Divorce	Year or I	Dates:		1 ⊔ Yes 2	ZLI No	Specify:			Spe	ecify:	
5-	72 hours after death with "naturel", or items 23a or dical Examiner must be	Completed		nt's Education est grade completed,	, 1	6a. Deced	dent's Usua kind of wor DO NOT us	l Occupa	ition Jurina most	t of worki	ina	16b. Kind o	of Business/I	ndustry
121	within ne. han	m	Elementary/Secondary (0-12)	College (	(1-4or 5+)	OWN		e retired,	)			DET	ΓAΙL	
d 21	Hygie Hygie ther I	ပိ	17. Father's Name (First, Middle	l act)		01111			10. Matha	win blanca	(Fire & Adiabate			
ano	ontal	Be	JACOB	LESI		חר	T T 7				(First, Middle,	maiden Sun	,	. T. O
Maryland	12 should be filed within and Mental Hygiene. 7 is marked other than "treumatic event, the Market	ှင	19a. Informant's Name/Relation	chin (Tuna Print)			ITZ	(Character)	SAR		10			ATISKY
<b>E</b>	id 2 s lth ar 27 is treu		ADELE DEITZ /								NALTIMO			
ē,	Heal Heal tem	-	20a. Method of Disposition		20b. Place	e of Dispo	sition /Nam	ne of	- 1				on - City or T	
no	ages ant of it: If i		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (	3 Removal from	State DRUID	RID	patory`or ot 3E	ther place	" [0				MORE,	
Baltimore,	permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Importent: If item 27 is marked other than any righty or other freumatic event, In M. ADGE.		21. Signature of Funeral Service						:	•	LEVINS(			
Ba	Dermi Depa Impo any ir	. 10	1Ret	1-7		89	OO RF	TSTE	RSTOL	YN BI	UVD - DI	INECNI NI W D	KUS.,	1NC. 4D 21208
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that	caused the death. D								LLL, I	Approximate
	/Medical Examiner hysician and private in private in private in the private in th	cal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	b	ON AR (or as a consequence (or as a consequence (or as a consequence	ce of):	TER	4	2/5	CEA	-S E			Onset and Death
P.O. Box 68	t the death certific by the attending p ached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live t	tcome of pregnancy birth 2   Fetal dea nant at time of death own	ath 3 🗆	Ectopic pre Other (spe						Date of delive	ery Day Year
S,	res tha igned l be det	by P	Part II. Other significant conditi					-	n in Part I.		23e. Did tob	acco use co	ontribute to ti	ne cause of death?
ırd	aquire en sig	edl	CHRONIC								1 ☐ Ye	s 2□No	3 Prob	ably 4 Donknown
of Vital Records,	aw requis been 2 should	Completed	BLADDER	CANCE	R						24a. Was a	n 241	b. Were auto	psy findings available
Ä	The lay ate has page 2	Eo	DEMERTI								autops	ned?	prior to co death?	mpletion of cause of
ita	iiclen: Th certificate rector, pag	a	25. Was case referred to medica						26 Place	of Death	(Check only on	No	1 🗌 Yes	2LI No
f <	nysic lis ce direc	To B	examiner? 1 ☐ Yes 2 🛣No	Hospital:	Inpatient 2 ER/	Outpatient	3□ DOA				ne 5 ☐ Reside		ther /Specifi	<b>/</b> )
0	ng Phy Iter this		27. Manner of Death  1   Natural  5   ☐ Pendir	28a. Date	of Injury 28b	. Time of Injury	28	c. Injury : Work?	at	2	8d. Describe ho	w injury occ	urred	,
Ö	endir sath. or: Af	atic	2 Accident investi	gation	in, buy rour,	injuny	М		es 2□N	lo				
Division	To the Hospitel or Attending Physicien: within 42 Hours atter death. To the Funerel Director: After this certifica completely filled in by the funeral director; p	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 286. Place	of Injury - At home, ing, etc. (Specify)	farm, stre	et, factory,	office		2	8f. Location (Sti City or Town	reet and Nur , State)	mber or Rura	l Route Number,
	in 24 hour in 24 hou the Funer pletely fill	edicai	29a. Certifier 1 ★ Certifyir (Check only one)	g Physician: To the Examiner: On the band man	best of my knowled asis of examination a ner stated.	lge, death and/or inv	occurred at estigation, i	t the time in my opi	, date and nion, death	place, a	nd due to the ca d at the time, da	use(s) and i	manner as st e, and due to	ated. the cause(s)
	To	Σ	29b. Signature and title of certifie	r			29c.	License	number				ned (Month,	**
,			bluron H.	WOLDEHA	WUT		1	1006	332	7	0	6/00	5/20	06
1	2 1		30. Name and address of person	who completed caus	e of death (Item 23a	-	rint)							
1	J		GIZAW WOLDER		+34 W. BE	ELVE	DERE	FAU	E, B	ALT	MORE,	MD.	21215	
	Sta Registra		31. Date filed (Month, Day, Year)		egistrar's Signature	4	lack	9						

DHMH 17 Rev 1/2001

**ORIGINAL** 

				Type or Print in Black Indelibi		•	•
			For State	State of Maryland / Departmen		Mental Hygier	ne
			Registrar		te of Death	Reg. I	162000 17099
	Physici	an	Decedent's Name (First, Middle, Li	() - 1/		2. Date of Death	3. Time of Death
	/Media	cal	MIMUNIO	O. Dickerson		5-23	-06 1154 <sub>M</sub>
	Examir	ier	4a. Facility Name (If not institution, gi	/e street and number) 4b. City,	, Town, or Location of Death		c. County of Death
			5. Social Security Number 6.	Sex 7. Age (In yrs. last birthday) If Unde	Baitime	ore	
10	Funeral		5. Social Security Number 6.	7. Age (In yrs. las birthday) If Unde Months	Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	7. 72		1-23-	64 Maryland
	land		10a. State 10b. County	10c. City, Town or Location			10d. Inside City Limits
	Man	ţ	MD	1 Baltion	$\Omega$		1 Nes 2 □ No
	1 the	Director	10e. Street and Number	10f. Zip	p Code	10g. (	Citizen of What Country?
	h wit		3440 Clif	tmont Nizerra	21213		0 < 1
	deal	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent Ever in U.S. If Yes, spe	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
9	after or it		1 Never Married 2 Married	1 Yes 2 No	_	Hican, etc.)	Black, White, etc.
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. In the matural, or items 23s or 28s-1 show event, the Medical Evandral must be notified.	Completed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	2 No Specify:		Specify: Black
7	72 h	ete	15. Decedent's E (Specify only highest gr	ade completed) (Give kind of wo	ork done during most of work	ing 16b.	Kind of Business/Industry
12	withir ne.	dm	Elementary/Secondary (0-12)	College (1-4or 5+)	ise retired)	1/	3,150
	filed within Hygiene. Ither than "		17. Father's Name (First, Middle, Last	Labo	of et	10	wing
Maryland	Mental   Mental   arked o	Be	$\Omega$ 1 1 $\rightarrow$ 1		16. Mouner's Name	(First, Middle, Maide	on Sumame)
2	should be ind Menta i marked umatic ev	ဥ	19a. Informant's Name/Relationship	Cross Prints / 1 / 1 / 10h Mailine Address	DUOT	es be	51
Z	2 e e 2	-	Tours E.D.	oka so 3440	s (Street and Number or Rura	A A Number, City	or Town, State, Zip Code)
e)	1 and 2 Health am 27 is	`	20a. Method of Disposition	20b. Place of Disposition (Na)	ma of	Date 200	Location - City or Town, State
5	00= 5		Burial 2 Cremation 3	Removal from State cemetery, crematory or o	other place)	Inda D	Location - City of Town, State
Baltimore,			4 □ Donation 5 □ Other (Speci 21. Signature of Funeral Service Lice	" NITIVI PHIOFI	altack 3	131/UBB	Uthners, MD
Ba	permit. Departrimports eny inj		16. 11	Lui Varia	The Corne	ve tru	eral Sorvices
			23a. Part1. Enter the disease, or com	plications that caused the death. Do not enter the mod	05 YORK I	Cd Balk or respiratory arrest.	5.MD 2/2/2 Approximate
	Discourse and		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	1.1.0	A spiratory arrest,	Interval Between Onset and Death
Ì	Physician /Medical		disease or condition resulting in death)	a tall myogaro	SIR anxAn	for	30 mus
	Examiner		- (	Due to (or as a consequence of):			
		-	Sequentially list conditions,	b			
V		Φ	if any, leading to immediate	Due to (or as a consequence of):			
*	ansit m	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
Č,	executed in and ial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  C			
760,	e be executed sicien and burial-transit		cause. Enter Underlying Cause (Disease or injury that initiated events	c			
68	= > w	cal	causes. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c			
68	= > w	cal	causes. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c			23d Date of delivery
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. Box 68	ital or Attending Physicien: The law requires that the death certificate ris after death. ris after death. ris Director: After this certificate has been signed by the attending phy led in by the funeral director, page 2 should be detached for use as the	To Be Completed by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of):  d.  23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 3   Ectopic pr 4   Pregnant at time of death 5   Other (sp 9   Unknown  Contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contribution.  28a. Date of Injury (Month, Day Year)  28b. Time of Injury M  28e. Place of Injury - At home, farm, street, factory building, etc. (Specify)  yesician: To the best of my knowledge, death occurred and manner stated.	26. Place of Death  26. Place of Death  27. Other: 4 \( \text{Nursing Hor} \)  28c. Injury at Work?  1 \( \text{Yes} \) 2 \( \text{No} \)  7, office  28. Injury at work?  1 \( \text{Yes} \) 2 \( \text{No} \)  29. Linguity at the time, date and place, a in my opinion, death occurred.  20. License number	24a. Was an autopsy performed?  1 Yes 2 N  Check only one  10 Residence  28d. Describe how injuited.  28f. Location (Street a City or Town, State and due to the cause)  and due to the cause (sad at the time, date and 29d. Da	Month Day Year  use contribute to the cause of death?  Poly No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify)  In occurred  and Number or Rural Route Number,  a) and manner as stated.  d place, and due to the cause(s)  Its signed (Month, Day, Year)
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Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical Certification: To Be Completed by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of):  d.  23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 3   Ectopic pr 4   Pregnant at time of death 5   Other (sp 9   Unknown  Contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contribution.  28a. Date of Injury (Month, Day Year)  28b. Time of Injury M  28e. Place of Injury - At home, farm, street, factory building, etc. (Specify)  yesician: To the best of my knowledge, death occurred and manner stated.	26. Place of Death  26. Place of Death  27. Other: 4 Nursing Hore  28c. Injury at Work?  1 Yes 2 No  29. Injury at Hore  29. Injury at Hore  29. Injury at Hore  29. Injury at Hore  29. Injury at Hore  20. License number	24a. Was an autopsy performed?  1 Yes 2 N  Check only one  10 Yes 2 N  Check only one  10 Yes 2 N  Check only one  10 Yes 2 N  Check only one  10 Yes 2 N  Check only one  11 Yes 2 N  Check only one  12 Yes 2 N  Check only one  12 Yes 2 N  Check only one  29 N  29 N  29 N  29 N  29 N  29 N  29 N  29 N  20 N	Month Day Year  use contribute to the cause of death?  No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify)  Iny occurred  And Number or Rural Route Number, e)  s) and manner as stated. d place, and due to the cause(s)  ste signed (Month, Day, Year)

ORIGINAL

			For State Registrar		State	of Maryla				lealth a Death		ental Hy	giene	2006	17900
	Physicia /Medic		1. Decedent's Nam Opal Get	me <i>(First, Middl</i> e, nevieve )	,							2. Date of Do Month June		2006	3. Time of Death 12:20 Р м
	Examin		4a. Facility Name Gilchrist	t Center					Tow	Location o	of Death			ounty of Death Baltimo	ore
	Funeral Director		5. Social Security 181 14 94 Usuel Residence of	440	.Sex 1 □ M 2 🔀 F	7. Age (In yr. 87	s. last birthday Yrs.	Months	Days	If Under Hours	Min.	8. Date of Bi (Month, D. NOV. 16	rth ay, Year) , 1918		place (State or Foreign ntry) Sylvania
	the Maryland 28a-f ahow notified at	tor	10a. State Maryland	10b. County	ore	10c. 0	City, Town or I							1	0d. Inside City Limits 1 ☐ Yes 2 No
	th with the 23e or 28s	Funeral Director	10e. Street and Nu 1 Brett	ct. 'Ap	t. 103"			10f. Z	ip Code 2122	1				of What Cour	ntry?
9036	urs a	ģ		rried 2 Married	Armed F	2⊠No ive	U.S. 13		edent of Hi ecify Cuba 2X No		gin? (Spec , Puerto F	cify Yes or No Rican, etc.)		Race - Americ Black, White, ecity: Whi	etc.
Baltimore, Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours Department of Heelth and Mental Hygiene. Important: If Itam 27 is merked other than "natural, any injury or other traumatic avant, Ita Madical Exa once.	Completed	(Spe Elementary/Sec.	15. Decedent's ecity only highest condary (0-12)	grade completed)	1-4or 5+)	(Giv	edent's Us e kind of w DO NOT Sales	ork done d use retired	luring most )	of workin	g		of Business/Ind	
yland	should be file and Mental Hy marked oths umatic avant,	To Be C	17. Father's Name Jacob Hai							18. Mothe		(First, Middle	, Maiden Su	mame)	
e, Mar	l end 2 sho leelth and im 27 is m her traum		19a. Informant's N Alberta I	Eaton (Da		100	23 B	ourb	n Ct	. Par	kvil]	le, Mai	er, City or To Syland	own, State, Zip 21234	Code)
ltimor	it. Pages rtment of trant: If Ita		4 Donation	Cremation 3 5 Other (Spe	cify)	State	Place of Disp cemetery, cre k Lawn	matory or Ceme	etery	6	/7/20	006		nore, M	wn, State Maryland
Ba	permit. Departr Importa		21. Signature of Fi	W. Bu	rkousk	2		Bruzo 1407	lzinsl Old	Laste:	nera] rn Av	Home Jenue F	ssex.	Maryla	and 21221
122pm 0 8760, <	Physician /Medical Examiner physicien and the prixal-transit	dicai Examiner	Spock, or heat Immediate Cause disease or condition resulting in death)  Sequentially list or acuse. Enter Under Cause (Disease or that initiated event resulting in death)	onditions, manufacture erlying r injury is	aSt Due to b Due to	(or as a conse	equence of):  At CU (a.								Approximate Interval Between Onset and Death
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lWDE ords, P	w requires that the de been signed by the s should be detached to	ea by P	Part II. Other signi	ificant conditions	contributing to d	eath but not re	sulting in the u	nderlying	ause give	n in Part I.			obacco use d		e cause of death?
ptel Juna Vital Records,	The law ate has b	e completed by	25. Was case refer	rred to medical							_	1 ☐ Yes	200No	death?	osy findings available apletion of cause of
O . 2	this in the state of the state	ation: 10 be	examiner? 1  Yes 2 2  27. Manner of Deat 1  Natural 2  Accident	No th 5 Pending investigate	28a. Date (Mon	Inpatient 2 of Injury	ER/Outpatier 28b. Time of Injury		Other 28c. Injury Work	r: 4 🗆 Nur:	sing Home	Check only o	lence 6/13	Other (Specify, curred	haspige
Division	rs efter de al Diracto	Ceruncation;	3 Suicide 4 Homicide	6 Could not determine	d 28e. Place	of Injury - At h ng, etc. <i>(Speci</i>	nome, farm, str	reet, factor	y, office		28	f. Location (S City or Tow	Street and Nu m, State)	imber or Rural	Route Number,
	the Hoapitel hin 24 hours the Funeral upletely filled	Medical		∠ Medical Ext	Physician: To the aminer: On the band man	best of my knoasis of examination stated.	owledge, deat ation and/or in	vestigation	, in my opi	nion, death	place, an occurred	d due to the d I at the time, d	cause(s) and date and place	manner as sta ce, and due to	ited. the cause(s)
	7 Viiii		29b. Signature and	rarl	im				: License	number			JUNE	ned (Month, D	200
	H		30. Name and addr  A A New  31. Date filed (Mon	No CETA	WES W	v) 66	01 1	Print)	lare	3 5	+ B	MITA	nor h	10 Z12	04
	State Registra			IUN 0 7 2	100	egistrar's Sign	K de	arte							

			For State Registrar	State of I	Maryland /	-	artment of H		Mental Hy	giene,	2006	17901
7%	Dhusia	- 5	Decedent's Name (First, Middle	e, Last)			T	•	2. Date of D		Year	3. Time of Death
	Physic /Medi			Robert C	Carl Eber	sol	е		June	04, Day	006	2:00 PM
	Exami		4a. Facility Name (If not institution	n, give street and number	er)		4b. City, Town, or	Location of Death	1	4c. C	County of Death	
40.		×,	Prince George'	-			Cheverl	4			ince Ge	
	Funeral Director		5. Social Security Number 216-24-0406	6. Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs. last b	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D Dec 1	orth lay, Year) 9, 193	Cour	place (State or Foreign ntry) nsylvania
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	wn or Lo	ocation				1	0d. Inside City Limits
	Mary fish	to	MD Princ	e George	Landov	/er						1 ☐ Yes 2 ☑ No
	r 28a	rec	10e. Street and Number				10f. Zip Code			10g. Citize	on of What Cour	ntry?
	h with	aiD	1702 Columbia	Avenue			20785			U.S	.A.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show myniury or other treumatic event, the Mudical Examiner must be nutilled at 2008.	by Funeral Director	11. Marital Status 1 Never Married 2 Marr	12. Was Decede Armed Force nied 1 Tyes 2[ If Yes, Give	s? XNo		Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		Black, White,	etc.
8	urel.		3 X Widowed 4 □ Divorced								Whit	
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12	within ene. then	mc	Elementary/Secondary (0-12)	College (1-4d			nist	/		1	ernment	tes
	e filed y of Hygie other i	BeC	17. Father's Name (First, Middle,	Last)	Tio	10111	11100	18. Mother's Nam	ne (First, Middle			
lan	should be and Mental marked of umatic eve	To B	Roscoe Clinton	Ebersole				Catheri	ne Park	s		
Maryland	shoul and M s mar	ļ.,	19a. Informant's Name/Relations	hip (Type, Print)	19	b. Mailir	ng Address (Street a	and Number or Ru	ral Route Numb	oer, City or	Town, State, Zip	Code)
	and 2 valth a 27 to er tre		David R. Ebers	sole /son	9	540	Jeanne C	ourt, La	urel, M	aryla	nd 2072	3
ore.	of He of He reference		20a. Method of Disposition	2 - 2	20b. Place o	of Dispo	sition (Name of matory or other place	9)	Date	20c. Loca	ation - City or To	wn, State
Baltimore,	permit. Pages: Department of H Important: If ite eny injury or ot		1 🔀 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		110		ige Mem Pl	1	7, 06	Dorse	ey, Mary	land
a	Departr Mports ony injudice.		21. Signature of Funeral Service	Licensee		22	Name and Addres	s of Facility	Homo D	7\		
_	20 E = 9		X HU HX	M	M00773	3	13 Talbot	t Ave. L	aurel,	Maryl	and 207	07-4389
SĘ	Dhysician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that cause only one cause on each	sed the death. Do	not ent	er the mode of dying	y, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition Fresulting in death)	a. Due to (or	as a consequence	> of):	170 18	1			-7	
	Examiner			6	as a curisoquence	, orj.	Con Va	·		TE		
		ē	Saguentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence	of):	count	V Ja	1	2		
d	cate be executed obysician and the burial-transit	Examiner	that initiated events	. 60	ona	-	02	lon	de	220	use	
o Ì	an ar irial-tı		resulting in death) Last	Due to (or	as a consequence	of):						
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39 x	as as	Physician/Med	IF FEMALE:	22a If was outcom	no of programmy							
Вох	res that the death certifi igned by the attending be detached for use as	cian	23b. Was decedent pregnant in the past 12 months?		2 Fetat death		Ectopic pregnancy Other (specify)			23	<ul> <li>Date of delive</li> <li>Month</li> </ul>	ry Day Year
P.O.	the d y the ached	ysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown		0 (						
σ. σ	s that ned b e deta	by Pł	Part II. Other significant condition	ons contributing to death	but not resulting i	in the ui	nderlying cause give	n in Part I.	23ø. Did	tobacco use	contribute to th	e cause of death?
rds	quire; n sig	ρ	Hyper	tensu	2				1 🗆	Yes 2	No 3 Proba	ably 4 Onknown
000	s been si s should	Completed	It ressert	used.	nn	۹ .			24a. Was	an	24b. Were autor	osy findings avaitable
æ	The fa	E								psy ormed?	prior to con death?	nptetion of cause of
Vital Records,	an: tifica tor, p	Be C	25. Was case referred to medical					26. Place of Deat	1 Yes		1 🗌 Yes	2LJ No
<u> </u>	ysici is cer direc	To B	examiner? 1 ☐ Yes 2 💢 No	Hospital: Inpa	atient 2 ER/O	utpatien	t 3 DOA Othe	1. 4 Nursing Ho			Other (Specify	1
n of	ng Ph ter th neral		27. Manner of Death  1 ☑ Natural 5 ☐ Pendin	28a. Cate of Ir		Time of Injury	28c. Injury Work	at 2	28d. Describe	how injury o	occurred	,
<u>ত</u>	endir sath. or: Af he fu	atic	Accident investig	gation	, ,			es 2□No				
Division	s after de	Certification:	3 Suicide 6 Could determ	ined 289. Place of	Injury - At home, fa etc. (Specify)	arm, str	eet, factory, office		28f. Location ( City or To	Street and I wn, State)	Number or Rural	Route Number,
	To the Hospital or Attending Physician: The lar within 24 hours after death.  To the Funera! Director: After this certificate has completely filled in by the funeral director, page 2	Medical (	29a. Certifier (Check only one) Certifyin	ig Physician: To the be Exeminer: On the basis and manner	of examination ar	e, death	occurred at the time restigation, in my op	e, date and ptace, inion, death occur	and due to the red at the time,	cause(s) ar date and pl	nd manner as sta ace, and due to	ated. the cause(s)
	Withir To the Comp	ž	29b. Signature and title of certifie				29c. License	number		29d. Date s	signed (Month, §	ay, Year)
			1/2	Porce	- /	n.	1 1.	30310	5	61	4/0	Cara
	Dr		30. Name and address of person	who completed cause o	f death (Item 23a)	(Туре,	Print)	11		-/	7/	
	7		James Cateveni	s, M.D. 30	01 Hospi	tal	Drive, Cl	heverly,	Maryla	nd 207	785	
55	Sta	-	31. Date filed (Month, Day, Year)	32. Regis	strar's Signature				, ,			
*	Registr	ar	JUN 0	7 2006 1	en H	1	needs o					
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			. For	State of Maryland	/ Department of		-	•	
			1 - State Registrar	ŕ	Certificate o		Reg. N	2006	17902
	Physic	ian	Decedent's Name (First, Middle,	· · · · · · · · · · · · · · · · · · ·			2. Date of Death	Day, Year	3. Time of Death
	/Medi		ly amber N	icole Ennals			5 2	4 2006	1:15 PM
	Exami	ner	4a. Facility Name (If not institution,	pilal at Eustan	4b. City, Town	s, or Location of Death	4	Ic. County of Death	1
	Funeral			Sex 7. Age (In yrs. last			8. Date of Birth	10100	place (State or Foreign
	Director		None	1 M 2 DF	Yrs. Months Day		(Month, Day, Yea	2006 Mi	place (State or Foreign intry)
	pug *		Usuel Residence of Decedent 10a. State 10b. County	100 City T	own or Location			7000	0
	Aaryla f shor	5	- 4		ambridgs				10d. Inside City Limits 1  Yes 2 No
	ith the Marylar or 28a-f show	rect	10e. Street and Number	07183767	10f. Zip Code		10a C	Citizen of What Cou	/
	th with	Funeral Director	GIT Carl	tuns Court	211			U.S.A.	
	ems;	iner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent o	f Hispanic Origin? (Spe uban, Mexican, Puerto F		14. Race - Ameri Black, White	can Indian,
36	s afte	Y.F.	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No	1 □ Yes 2 🔀 N		iloan, bio.)	Specify: R	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23a or 28a-f show ont, tre Modical Exactinat must be notified at	Completed by	15. Decedent's	Year or Dates:	6a. Decedent's Usual Occ	unation	16h		
215	hin 72 9. "na Madii	plet	(Specify only highest of Elementary/Secondary (0-12)	grade completed)  College (1-4or 5+)	(Give kind of work dor life. DO NOT use reti	ne during most of working red)	100.	Kind of Business/Ir	idustry
	ygien ygien yer th	Con	Ö	0	none				
and	be fill Hall Hall Hall Hall et oth	ae	17. Father's Name (First, Middle, La	,	. \ .		(First, Middle, Maide		_
Maryland	2 should be filed within 72 hours after dea and Mental Hygiene. Is marked other then "natural", or Items eumatic event, if a Modical Examinerm	10	19a. Informant's Name/Relationship	rednick Enn			Troche		ng US
	and 2 salth and 2 salth and 27 ls		Latoya Wongus		9b. Mailing Address (Stre	ns Court			Cade)
Je,	of Health item 27		20a. Method of Disposition	20b. Place	of Disposition (Name of Itery, crematory or other p	Da	ate 20c.	Location - City or To	own, State
<u>E</u>	Pages nent of ent: If its ury or o		1 ☐ Burial 2 ☐ Cremation 3	city) Huspitul dispus		1			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then "natural", or Items 23a or 28a-f show any injury or other treumatic event, if a Madical Exercites must be notified at once.		21. Signature of Funeral Service Lice Ronald S	Wade Jirector	22. Name and Add State Ana	ress of Facility	655 W Ba	1timore 9	Stroot
	70 F 4 9		somme	1/1/REC	<del>- paltimore</del>	, MD 21201		TCTHOIC (	octeet
			shock, or heart failure. List on Immediate Cause (Final	100		ying, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician / Medical		disease or condition resulting in death)	a. AS PNY X TO					
	Examiner		2	b. Severe	One matur	Ay			
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (of as a consequent	e or).	1			
	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	-				
8760,	The law requires that the death certificate be executed site has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	cal E		Due to (or as a consequence	e or):				
687	ificate g phys			d					
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B.	s deat he atte ed for	Physiclan/Med	in the past 12 months?	1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown	th 3 ☐Ectopic pregnan 5 ☐ Other (specify)	cy		Month	Day Year
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co	w require been si should b	lete							
Re	The lar	Completed					24a. Was an autopsy performed?	death?	psy findings available mpletion of cause of
		BeC	25. Was case referred to medical			26. Place of Death (	1 ☐ Yes 2 X No Check only one)	1 ☐ Yes	2∕S No
of V	Physician: this certifica ral director,	101	examiner? 1 D Yes 2 No	Hospital: 1 Inpatient 2 ER/C	Outpatient 3 DOA	4	e 5 Residence	6 □Other (Specify	")
	ling After une	lon:	27. Manner of Death 1 Natural 5 □ Pending	(Month, Day Year)		ork?	ld. Describe how inju	ry occurred	
Division	ne sat	ficat	2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	be One Plans of John Athama		Yes 2 No	f Location (Street a	ad Mumbas as Dum	/ Davida Alice A
5	el or / s after il Dire d in b	Certification:	4 Homicide determine	building, etc. (Specify)	raini, street, ractory, onice		lf. Location (Street ar City or Town, State	e)	Houte Number,
	To the Hospitel or Att. within 24 hours after de To the Funerel Direct. completely filled in by ti	calC	29a. Certifier 1 Certifying F	hysician: To the best of my knowled	ge, death occurred at the t	time, date and place, an	d due to the cause(s	) and manner as st	ated.
	the H nin 24 the F nplete	Medical	one)	miner: On the basis of examination a and manner stated.	and/or investigation, in my	opinion, death occurred	at the time, date an	d place, and due to	the cause(s)
1	or vitt	Σ	29b. Signature and title of certifier	Tan IM		se number		te signed (Month, L	
7			20 Nama and different	Completed of the first first	700	うりかんて	7 0	5-90-	-0/2
			30. Name and address of person who	completed cause of death (Item 23a	505 A D	55829	s Ln E	agter v	no 21601
::	Sta		31. Date filed (Month, Day, Year)	Registrar's Signature	Prost o				~ - (
	Registr	ar	JUN 0 7 201	Jo States of a					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. C. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 9:01 AM Mar asmine 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Bultmore NIA Mary land 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04 27 1991 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or itame 23a or 28a-f show the Medical Examiner must be notified at Harford 1 ☐ Yes 2 No MD Edgewood Be Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2901 Ancon Court 21040 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12)

9th grade Student Education other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, and Mental F Eure Reid James Aretha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2901 Ancon Edgewood MD 21040 if item 27 i Eure Father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State ŏ Depertment of Important; if eny injury or once. reenmount eventation 06.05.06 4 □ Donation 5 □ Other (Specify) 28 Name and Address of Eaching
Vaughn C. Greene Funeral
4405 York Road Baltimore 21. Signature of Funeral Service Licensee Funeral Services n mo 1363 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician +UN9 /Medical Examiner VERE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Medical Certification: To Be Completed by Physician/Medical Examiner use as the burial tran To the Hospital or Attending Physician: The law requires that the death certificate be execuympho blastic Leukemia Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown page 2 should be detached 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an autopsy 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 2 No 1 Inpatient 1 🗌 Yes 2 ☐ ER/Outpatient 3 ☐ DOA 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours efter deatl To the Funeral Director; completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 📈 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ug. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	Cer	tificate of De	eath		Re	g. No.	00 1790
Physic		1. Decedent's Name (First, Middle,L					Date of Deat     Month	Day Year	3 Time of Death
Medical Exam	ingr	John Frost III		14.0	9 Y 1	ation of Dooth	May 14, 20	006	0932 hrs
		4a Facility Name (if not institution, a 2009 Robb Street	give street and number)		ity, Town, or Loc altimore	ation of Death		4c. County of D	Death
Funeral			Sex 7. Age (In yrs. Ia			If Under 24Hrs	. 8. Date of Birt	h(MM/DD/YYYY) 9	). Birthplace (State or
Director		unk			onths Days	Hours Min.			oreign unk
		Usual Residence of Decedent	X M 2 F 48	113.			May 13	3 <b>,</b> 1958	**
any		10a. State 10b. County	10c. City,	Town or Location					10d. Inside City Limits
Maryland 28a-f show 1 at once.	ō	MD	Bal	timore					1 X Yes 2 No
Maryl 28a-1 d at o	Director	10e. Street and Number		10f	Zip Code		10	g. Citizen of What	Country?
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ter dea ', or i	ш	لبيدا	1 Yes 2 X No	1 Yes	2 X No s	necify:		Specify:1	
urs afi tural	d by	15. Decedent's Education (Specify	or Dates:	16a. Decedent's Us	sual Occupation	(Give kind of w		Specify: w	ess/Industry unk
72 ho	ete	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of	working life. DC	NOT use retir	red)		ulik
5-0036 led within 72 Hygiene. other than '	omplete	12	none	Auto Wo					· · · · · · · · · · · · · · · · · · ·
	၂ပ	17. Father's Name (First, Middle, La	•		18.N	Mother's Name	(First, Middle, M	laiden Surname)	unk
21215-00) build be filed with I Mental Hygiene marked other t	o Be	John Russell Fr  19a. Informant's Name/Relationship	and the first of the state of t	19b. Mailing Add	ress (Street an	d Number or R	tural Route Num	ber, City or Town, S	State Zip Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 7 ment of Health and Mental Hygiene. Itant: If item 27 is marked other than re orber reaumatic event, the Metheria		Jonathan Karrer	/room mate	401 Yal	e Ave. F	Raltimo	re MD '	21220	
2 2 2 3		20a. Method of Disposition	20b. P	Place of Disposition rematory or other pl	(Name of cemete	ery,	Date	20c. Location - Cit	y or Town, State
Baltimore, permit. Pages I an Department of Hee Important: If ite		1 Burial 2 Cremation 4 Donation 5 X Other Spec	Tremoval from State	rematory or other pr	ace)				
Baltimo permit. Pages Department o Important: I	1	21. Sign there of Funeral Prince Lice Ronald S	ensee Wirector	22 Name	and Address of I	Facility Boar	rd 655 W	I Raltim	ore Street
	9 9	11 unani	11/ tel	Bal	timore,	MD 212	01		
Physician /Medical		23a. Part I Enter the disease, or confailure. List only one cause on	each line.	Do not enter the mo	ode of dying, suc	h as cardiac o	r respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
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cuted nd ransit		evento resulting in deathy last	d						
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68760, certificate be ex nding physician se as the burial	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregn		. D			23d Date of deli	· .
Sox 687 leath certific e attending for use as t	sician	past 12 months?	1 Live birth 4 Pregnant at time of dea	2 Fetal de ath 5 Other (		Ectopic pregna	ncy	Month	Day Year
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Vital Rec ysician: The his certificate director, page	Be (	25. Was case referred to medical examiner?	Hospital:		- Ioth	Death (Check o			
Division of Vital Records, tal or Attending Physician: The law require she ded cheeper and a been significant. After this certificate has been signed in by the funeral director, page 2 should the content of the conte	2	1 ✓ Yes 2 No 27. Manner of Death	I Inpatient 2	ER/Outpatient 3 28b. Time of Injury	DOA Other	TTUTSITE		Residence 6 🗸 C	Ither: Scene
n of riding Ph. th. : After i	ion:	1 ✓ Natural 5 Pending	(Month, Day, Year)	200. Time of injury	1 Yes		200. Describe III	ow injury occurred	
ision Attencer er death rector: by the	icat	2 Accident Investig	ation 28e Place of Injury - At ho	me, farm, street, fac			28f. Location (St	treet and Number of	r Rural Route Number, City
Div ital or ral Di	Certification:	Suicide 6 Could n  4 Homicide			-		or Town, St		
Hosp 24 hou Functiely fi		20a Certifier	ician: To the best of my knowledge	e, death occurred a	t the time, date a	and place, and	due to the cause	(s) and manner as	started.
Division of Vital Records, P.O. I To the Hospital or Attending Physician: The law requires that the within 24 hours after deeger.  Completely filled in by the funeral director, page 2 should be detached.	Medical		ner: On the basis of examination an	nd/or investigation, in	n my opinion, dea	ath occurred at	t the time, date a	nd place, and due t	o the cause(s)
F 3 F 3	M	29b. Signature and title of certifier			29c. License nu			29d. Date signed	(Month, Day, Year)
		HILLIAM	/ / /		O.C.M.E			May 15, 2006	
		30. Name and address of person wh			root Politics	oro MD 241	201		
		Susan Hogan MD. As  31. Date filed (Month, Day, Year)	sistant Medical Examiner  3 Registrar's Signatur	111 Penn St		JIE, IVID 214	201		
S Regis	tate trar	11 N 0 7 20	E Le	forti					

			For State Registrar	State o	f Marylar		artment of H	Health and N Death		giene Reg. No. 2006	1790
	Dhusia	7	1. Decedent's Name (First, Midd						2. Date of Dea	ith	3. Time of Death
	Physic /Medi		John Will						June	S 2006	0730 M
	Exami	ner	4a. Facility Name (If not institution	on, give street and nur		aston	-	r Location of Death		4c. County of Death	b
12	Funeral	*\da	5. Social Security Number		7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	lalbo	
	Director	Н	219-12-6136	6. Sex XIZM 2□F	82	Yrs.	Months Days	Hours Min.	Jan. 20	(Year) Cou	nplace (State or Foreign untry) ryland
_	and w		Usual Residence of Decedent  10a, State 10b, Count	,	10c Ci	ty, Town or Lo	ontion				
	with the Maryland a or 28a-f show	io		aroline	100.01		ensboro				10d. Inside City Limits 1 ☐ Yes ※XNo
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	th with	aiD	25519 Linha	ard Lane				1639		U.S.	,
2	er death v	Funeral Director	11. Marital Status	12. Was Dece Amed Fo	edent Ever in U	J.S. 13. V	Vas Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-	14. Race - Amer Black, White	ican Indian,
7	irs aft	by F	1 ☐ Never Married XX Mai 3 ☐ Widowed 4 ☐ Divorce		2⊡No /e ates:WWI		□Yes XXNo	Specify:	,		nite
Joh 215-0036	within 72 hours after death with the Marylar ane. then "natural", or Items 23a or 28a-f show a Maryleal Examinan must be multied at	ted	15. Deceder	nt's Education		16a. Deced	ent's Usual Occup	ation	1	16b. Kind of Business/Ir	
7 7		Completed	Elementary/Secondary (0-12)	college (1	-4or 5+)	life. L	O NOT use retired	,	ng		
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and	d be f antal h ced of	9 Be	Adolp		e 1			18. Mother's Name Eva	Gaiq1		
ede/	2 should be fitted within and Mental Hygiene. Is marked other then sumatic event, the Mental Hygiene.	2	19a. Informant's Name/Relations	<del></del>		19b. Mailin	Address (Street			, City or Town, State, Zi	n Code)
	s 1 and 2 should be fited within f Health and Mental Hygiene. Item 27 Is marked other then other traumatic event, the Ma		Geneva Fried	e1 / Wife	e					boro, MD	
Fr. Baltimore	0 0		20a. Method of Disposition  XDurial 2 Cremation	3 Pernoval from 9	State 20b. F	Place of Dispos cemetery, crem	ition (Name of atory or other place	(e)		20c. Location - City or T	
一章	t. Pag rtment rtant: I		4 □Donation S □Other (S	Specify)	Net		nd Ceme		/7/06	Sykesvil:	
Ba	permit. Departr Import. eny inji		21. Signature & Furieral Arvice	Licenson	m	22.	Name and Addres	ss of FacilityEck	hardt F	uneral Ch	apel P.A.
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Вох	ath ce	Physician/Med	23b. Was decedent pregnant in the past 12 months?		rth 2 Fetal	death 3 🗆	etopic pregnancy			23d. Date of delive	•
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Division of Vital Records,	ysicisn: Th	Be	25. Was case referred to medical examiner?	Hospital:				26. Place of Death			2010
ō	Phys r this rat dii	. To	1 Yes 2 No	28a. Date of		ER/Outpatient 28b. Time of		4   Nursing Hom		nce 6 Other (Specifi	/)
on	Attending r death. sctor: After by the funer	ition	1 Natural 5 Pendin 2 Accident investig	g (Month	, Day Year)	Injury	28c. Injury Work	at ? es 2 □ No	8d. Describe hov	w injury occurred	
V <sub>i</sub> S	ar dear rector	Certification:	3 Suicide 6 Could in determined	ined   286. Place c	of Injury - At ho	me, farm, stree	it, factory, office		8f. Location (Stre	eet and Number or Rura	I Route Number.
Ō	ital or rs afte ral Dir		- I nominate	Dullani	g, etc. <i>(Specify</i> -	7			City or Town,	State)	
	Hospital	icai	29a. Certifier Certifyin (Check only 2 Medical:	g Physician: To the b Examiner: On the bas	est of my know	wledge, death o	occurred at the time	e, date and place, a	nd due to the cau	use(s) and manner as st le and place, and due to	ated.
	To the Hospital or Attanding I within 24 hours after death.  To the Funeral Director: After completely filled in by the tuner	Medicai	one)  29b. Signature and title of certifier	and maining	er stated.		29c. License				
	F 3 F 8			1	10	00				d. Date signed (Month, I	
	d		30. Name and address of person	who completed cause	of death (Item	23a) (Typa D	1)003	3110	J	June 5	200 /2
	0		De Dennis	De Shields	219	15 Wa	shinton	St Za	ston, mi	21601	
1	Sta		31. Date filed (Month, Day, Year)	Committee of the commit	gistrar's Signat	ure	0				
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						OTHOUR!	L.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 6 12:300 6 va Bever 06 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Charlestown Care Center Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Min. Months Days Hours 1 □ M 2 🛛 F Yrs. 217-14-0712 Jan.4, 1923 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Catonsville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 709 Maiden Choice Lane 21228 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4+ Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hamilton W. Rouse Edna Zahrendt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5 Seyon Court; Baltimore, Maryland 21228 Gail Ford Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 6/9/2006 Lorraine Park 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, Maryland 21. Signature o Funeral Service License 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neummia

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

Directo

Funerai

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Completed

Be

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**Funeral** 

Director

item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Modical Experience over the notified at

permit. Pages 1 and 2 should be tiled within 72 hours after o Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or then any injury or other traumatic event, the Medical Exercities and

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

the Maryland

With

death

Hospital or Attending Physician: The law requires that the death certificate be executed

Examiner attending physician and for use as the burial-transit Physician/Medical ed by the a should be det ģ Completed certificate has b irector, page 2 sl Director: Alter this certific I in by the funeral director, Be Certification: filled in by

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

Dene 25. Was case referred to medical examiner?

27. Manner of Death

1 Anatural

2 Accident

3 TSuicide

29a. Certifier

Medical

State

Registrar

4 Homicide

(Check only one)

1 ☐ Yes 2 ZMo

in the past 12 months?

Ancrepia

-tra

5 Pending investigation

6 Could not be determined

IF FEMALE

Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 4□Pregnant at time of death 9 Unknown

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year)

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No

24a. Was an autopsy performe 1 Yes 2/2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Year

26. Place of Death (Check only one) Other:

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

have have, Carnsville, mp 2/228

tertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

1744377

29c. License number

29d. Date signed (Month, Day, Year)

Deween Inus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

nis

Bowlin 31. Date filed (Month, Day, Year) JUN 0 7 2006

32. Registrar's Signature

711

To the Hospital within 24 hours a To the Funeral I

Please Type or Print in Black Indelible Ink

lbert Green		1- For State Registrar	tate of Maryla		partment of partificate of		Mental H	F	reg. No	006	1790
Physicia Medical Examir		1. Decedent's Name (First, Mid- Albert G	dle,Last) $r$ ee $n$					2. Date of Dea Month May 29, 2	Day Year		of Death
		4a. Facility Name (if not institut	ion, give street and nu	mber)		4b. City, Town, or L	ocation of Death	ay 20, 2	4c. County of	Death	
Funeral		Harbor Hospital  5. Social Security Number	6. Sex	7 Age (In vrs	. last birthday)	Baltimore  If Under 1 Year	If Under 24Hrs.	8 Date of B	N/A	9 Suthplace (	State or
Director		243-29-3519	1 X M 2 F	43	Yrs	Months Days	<del></del>	7	2/1962	Foreign Country)	
		Usual Residence of Decedent						01/22	2/1902		
Maryland 28a-f show any 1 at once,		10a. State 10b. County		1	ty, Town or Locat						res 2 No
aryland 8a-f sho at once.	Director	MD N/ 10e. Street and Number	A	B	altimor	°E 10f. Zip Code		<del>-</del> 1:	 10g. Citizen of Wha		C3 Z
the Mais or 23		133 West Jef	frey Str	eet		21225	i		U.S.A.		
Truck Driver  MD N/A Baltimore  106. Zip Code  1225  107. Zip Code  108. Street and Number  109. Zip Code  109. Zip Code  110. Zip Code  1225  111. Marital Status 112. Was Decedent Ever in U.S. 113. Was Decedent of Hispanic Origin? (Single Year or Dates) 114. Never Married 2 Armed Forces? 115. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use results of the property of the proper									0- 14. Race - White,	American India etc	in, 8lack,
s after rral", c	ᇍ		ivorced If Yes, Give Yea or Dates:			Yes 2XX No				Black	
5-0036 led within 72 hours after tygiene other than "natural", the Medical Examiner	Completed	15. Decedent's Education (Sp Elementary/Secondary (0-12				it's Usual Occupatio ost of working life. I			16b. Kind of Busi	iness/Industry	
vithin 7	E I	12			Truck	Driver	•		Faulkne	er Dist	t. Co.
21215-0036 Juld be filed within 7 Mental Hygiene marked other than event, the Medica	Be Co	17. Father's Name (First, Middle Howard Gre				1			Maiden Surname)		
Z = 용 를 함	- 1	19a Informant's Name/Relation			19b. Mailing	Address (Street	Shirle; and Number or R			State, Zip Cod	e)
ore, MD 2 tes 1 and 2 shou of Health and P If item 27 is r ther traumatic	1	Grochelle B	elton (	Sister	r) 133	West Je	ffrey	St.,Ba	ltimore	, Md.	21225
Baltimore, permit Pages I at Department of Hee Important: If ite	1	20a Method of Disposition  1 Burial 2 X Crematic	on 3 Removal fro	om State	Metro Crei	ition (Name of ceme her place) ALOLY		Date	20c Location - C	,	
Baltimo permit Page Department of Important: injury or oth	4	4 Donation 5 Other 5 21 Senature of Funeral Service		<del> M-1</del>	t. 210n	Cemeter	y 06/0	05/200	β <del>Lansd</del>	ille, <del>lowne</del> ,	Md.
Ba perm Depig	4	EUDONIE X	Male	OR 6	¥ Es	lame and Address of tep Bro 00 Euta	thers w Place	Funera e.Balt	l Servi	Ma. 2	21217
Physician /Medical		23a Part   Ent r the dise e, o fail   List only one caus	or complications that a e on each line.	aused the dea	Do not enter t	he mode of dying, si	such as cardiac or	respiratory are	rest, shock, or hear	t Approx	ximate Interval
Examiner		Immediate Cause (Final diseas or condition resulting in death)	e a. <u>Pneumon</u> Due to (or as a			quired immu	nodeficie	ncy_			Death
		Sequentially list conditions,	b	Consequence	. 61).						
	ij	if any, leading to immediate cause. Enter Underlying Cause		consequence	of):						
ed isit	Examine	(Disease or injury that initiated events resulting in death) Last		consequence	of)						
	Physician/Medical I	X UNPENDED	X AMENDED	item#11	,20a-c,pe	rFH,G856,6/	7/06 TT /	/ item#23	Ba.27.perME	.G857.7/1	 0/06 TT
760, ficate b	/Me	IF FEMALE: 23b. Was decedent pregnant in	the	outcome of pre	egnancy				23d Date of de	elivery	
Box 687 death certiffcc he attending p d for use as th	iciar	past 12 months?	4 Pregn	irtn ant at time of	dooth	tal death 3 _ her (Specify)	Ectopic pregna	ncy	Month	Day	Year
. Bo he deat y the at	hys	1 Yes 2 No 9 U	9 OHKIIC		Landing in the		W. la Paul	DOS BINA			
ords, P.O. w requires that the sbeen signed by should be detach	<u>آڅ</u>	Part II. Other significant cond	contributing to	geath but not	t resulting in the t	underlying cause giv	ven in Part I.		obacco use contribus 2 No 3		
Division of Vital Records, ral or Attending Physician: The law requir rs after death  al Director: After this certificate has been seed in by the funeral director, page 2 should be	Completed						·	24a Was autor		ere autopsy find or to completion	
Recol The law cate has	E O								rmed? de	ath? ✓ Yes	2 No
	Be	25. Was case referred to medic examiner?	Hospital				of Death (Check of Death (Chec				
Division of Vital   Hospital or Attending Physician: 24 hours after death Funeral Director: After this certif	유	1 Yes 2 No 27. Manner of Death	28a. Date (Month		ER/Outpatient 28b. Time of I				Residence 6 how injury occurred	Other:	
ion (tending eath or: All the fur	tion		nding	, Day,Year)		1 Ye	es 2 No		, ,		
ivisi or Att after de Direct	Certification	3 Suicide 6 Coi	uid not be	e of Injury - At	home, farm, stree	et, factory, office bui	ilding, etc.	28f. Location (	Street and Number	or Rural Route	Number, City
Divi		4 Homicide	ermined (Specify)								
the the	Medical	(Check only   Certifying	Physician: To the bes aminer: On the basis of	of examination							)
- J V	Me.	29b. Signature and title of certif	and manner s	tateu		29c. License	number		29d Date signed	(Month, Day, Y	rear)
2000		Mayone	Me Bru	L		O.C.M	1.E.		May 29, 200	6	
· Clit		<ol> <li>Name and address of person</li> <li>Margarita Korell MD.</li> </ol>	on who completed caus Assistant Med	·		enn Street, Bal	Itimore. MD 2	21201			
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature											
Regist	rar	JUN 0 7	2006	38 e 25. 4	St. Goa	de					

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death May 24, 2006 **Physician** Year 07:45 Anna Gerecht /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wilson Health Care Center Gaithersburg Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 M 2 X F Yrs 216-01-3754 92 Director Nov 18, 1913 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ☐ Yes 2x No MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23s 301 Russell Avenue 20877 Funerai USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Importent: If Item 27 Is marked other than "natural", or Iter Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Layout Artist Airplane 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frederick Peter Gerecht Anna Mary Lang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilson Health Care Center 301 Russell Ave. Gaithersburg, MD 20877 Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 XDonation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 'n www that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a on each line. Enter the disease, or complications, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician west /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physicien and for use as the burial-transit the Hospital or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 menths?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: Medical Certification: To 1 Tes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funerel Director: A 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide pellit 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUN 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** June 6, 2006 Sue 5:25 an /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Apt 201 Baltimore 11427 Eastern Avenue Middle River If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Director 4, 212-60-3458 1952 June Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "nature!', or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be martified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Baltimore Middle River 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 11427 Eastern Avenue 21220 Funeral Apt 201 S. A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Cecil Jernigan Virginia Grace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Lee Gross, Jr. (Husband) 11427 Eastern Avenue Middle River, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/9 2006 4 ☐Donation 5 ☐Other (Specify) Gardens of Faith Cem. Baltimore, Maryland <sup>22. Name and Address of Facility</sup> Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 21. Signature/of Funeral Service Licensee okm Durkouske Fat1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 0000 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ettending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown β bete has been signed page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death þ 1 Yes 2 No 3 Probably 4 Nhknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 Yes 2 No 1☐ Yes Director; After this certification by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 1 ☐ Yes 2 XNo 27. Manner of Death Certification; 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifile 29c. License number alle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Naresh Khanna, M.D. 901 Eastern Blvd. Baltimore, Maryland 21221 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State JUN 0 7 Registrar 2006

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 20 b per fh 8856 6-7-06 vt

State of Maryland Department of Health and Mental Hygiene Reg. No. 2006 1 - For State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 23<sub>PM</sub> Year **Physician** CAYLE RICE CATHERIN E 25 06 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges medical Conten Prince Georges Cheverly Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Yea 3 / 1 / 30 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Days Hours 1 □ M 2 🖫 F Yrs 141-22-867 Director Usual Residence of Decedent Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heelih and Mental Hygiene. Important: if item 27 is marked other then "natural", or teme 23a or 28a-f show any injury or other treumatic event, it a Mudical Examinar most be notified at once. 1 Yes 2 No Prince Georges Capital Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Falkland Place USA 20743 Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Specify: African 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced American 16a. Decedenl's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Substitute Public Education Jeacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Rice Rhoda Cornelius 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Falkland Place, Cap. tal Heights, MAD Jame of Date 200. Location - City or Town, Slate Mrs. Robn Burk 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 200 Paca of Dispositor (Name of Lyther place) Pleasantville, N.T 6/3/06 Gem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Se Fineral Service. P. 16 Hard 5, 26 Before Road, Batt, 140 21. Signature of Funeral Service License Balt, MO ZIRA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PULMONARY EDGMA **Physician** ACUTE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DISCASE BRTERY CURONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires thet the death certificate be executed burial-transit HYPGR TGNSION that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. HYPER CHOLESTROLE MIA. Be Completed by Physician/Medical ate has been signed by the attending phys page 2 should be detached for use as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 9☐ Unknown 5 Other (specify) Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown WITH NEPHRUSI 8 DIANGES 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? GOUT PRIOR STROKE REFLUX DISEASE ESOPHAGEIR 2□ No GASTRO 1 TYes 1 Yes 2 No Division of Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred 27. Manner of Death After Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 / Homicide 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1 40395 5/30/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Saraswathy Ramachan dra PG Medical amachan dran 31. Date filed (Month, Day, Year) 32 Registrar's Signature,

State

Registrar

0 7 2006

		-	For State Registrar	State of N	Maryland / Dep Ce	partment of Hertificate of L			iene eg. No.2 0 0 6	791
			1. Decedent's Name (First, Middle, L	ast)				2. Date of Deat	Daw Year	3. Time of Death
	Physicia /Medic			Warre	en T. Holly			06/02	12006	3.30/M
	Examin		4a. Facility Name (If not institution, g	ive street and numbe	r)	4b. City, Town, or			4c. County of Dea	
				Sare-Wincheste	er Sandtown Age (In yrs. last birthda	y) If Under 1 Year	Ba If Under 24 F	Itimore  Irs. 8. Date of Birth		V/A
	Funeral Director		212-32-5358	1 M 2 □ F	69 Yrs.	Months Days		lin. (Month, Day,		thplace (State or Foreign ountry) Maryland
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location		-		10d. Inside City Limits
	Maryl f sho	ρ	Maryland	N/A		Ba	ltimore			1 X Yes 2 □ No
	1 the	Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
	h with	a D	4408 Woodlea Avenue	•			21206		U.S	5.A.
	ams	ner	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S. 13 s?	. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? n, Mexican, Pu	(Specify Yes or No- jerto Rican, etc.)	14. Race - Am- Black, Whi	
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or itams 23a or 28a-f show event, the Mudical Exertical termatical and event, the Mudical Exertical termatical and event, the Mudical Exertical termatical and event.	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced		₹No	1 ☐ Yes 2 ☑ No	Specify:		Specify:	Black
Ö	72 ho	ted	15. Decedent's (Specify only highest of	Education	16a. Dec	edent's Usual Occupa	ation	working	16b. Kind of Business	/Industry
2	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-40	lite	DO NOT use retired	)		Baltimore (	City Dept. of
N	filed w Hygier othar th		17. Father's Name (First, Middle, La			Environmen		Name (First, Middle, I	Maiden Sumame)	
$\subseteq$	should be filed within and Mental Hygiene. s markad othar than umatic evant, the M.	То Ве		rill Holly					lma V. Hall	
lan	is ar		19a. Informant's Name/Relationship	(Type, Print)		,			City or Town, State,	Zip Code)
d)	s 1 and 3 Health itam 27 other tr		Tiereachie Holly Wife 20a. Method of Disposition		20b. Place of Dis		Avenue Ba	altimore, Maryla	and 21206 20c. Location - City or	Town State
Baltimore,	permit. Pages Department of It Important: If its any injury or of		1 🔀 Burial 2 □ Cremation 3		te cemetery, cr	ematory or other place		06/08/06		Maryland
薑	iit. Pa artme ortant injury		' 4 ☐ Donation 5 ☐ Other (Special Signator) of Funeral Service Lice			utus Memorial F 22. Name and Addres		00/00/00	Dalumore	, ivial yla i iu
Ba	Depa Impo any ir once		) Tour	1 58	TOA	Estep Br	others Fu	neral Service, F	P. A.	
	100		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caus	sed the death. Do not e	nter the mode of dying	taw Place g, such as card	Baltimore, Md diac or respiratory arre	est,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition		ero sclo	ratic Ca	rdio	Vasculer	- Diseas	Onest and Onest
	/Medical		resulting in death)	a. Due lo (or :	as a consequence of):	1 60				
	Examiner	L	Sequentially list conditions, if any, leading to immediate	b. Enc	ephal	opa Ky				
$\mathcal{J}$	ed sit	Examiner	cause. Enter Underlying	Due to (or a	as consequence of):	1				
12	s be executed sician and burial-transit	xan	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or a	as a consequence of):					
8760,	death certificate be executed e attending physician and id for use as the burial-transit	calE		d						
89	tificate g phys as the			V						
Вох	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		☐Ectopic pregnancy			23d. Date of de	·
Э.	the att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of death 5	Other (specify)			Month	Day Year
P.0	by tac		9 ☐ Unknown  Part II. Other significant conditions	contributing to death	hut not resulting in the	underlying cause give	on in Part I	23a. Did tot	bacco use contribute t	o the cause of death?
Records,	es ign be	ed by	Fatti. Other significant conditions	commoding to dean		underlying cause give				robably 4 Onknown
000	law requir as been s 2 should	Completed						24a. Was a	n 24b. Were a	utopsy findings available completion of cause of
Ä	0 4 0	mo;						perform	med? death?	1
	ysician: Th is certificate director, paç	Bec	25. Was case referred to medical examiner?					Death (Check only on	-	
of <	99 50 ==	2	1 □ Yes 2 No	Hospital: 1 ☐ Inpa		The state of the state of	4 Nursin		ence 6 Other (Spe	ecify)
		lon:	27. Manner of Death  1 Matural 5 Pending	28a. Dale of li (Month, i	njury Day Year) 28b. Time Injury	Work	rat <br Yes 2 □ No	28d. Describe ho	ow injury occurred	
Division	Attending r death. actor: After by the fune	icat	2 Accident investigat 3 Suicide 6 Could not	be one Place of	Injury - At home, farm,		2 110	28f. Location (St	reet and Number or R	ural Route Number.
Σ	al or A s after il Dira	Certification:	4 Homicide determine	building,	etc. (Specify)	on out, restory, smoo		City or Town		
	To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the	cal	(Check only 2 Medical Ex	eminer: On the basis	st of my knowledge, desof examination and/or stated.	investigation, in my or	oinion, death of	ccurred at the time, da	ate and place, and du-	e to the cause(s)
	To the within 2 To tha comple	Me	29b. Signature and title of certifier	10	Α -	29c. License	number	2	9d. Date signed (Mon	th, Day, Year)
			1 heggt	Her	MD	04	740	2	6/5/00	5
	11		29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person where the second of	completed cause of	821 No	o. Print) Euto	tem	Balt	imore n	1021201
	Sta Registr	ite ar	31. Date filed (Month, Day, Year) JUN 0 7	32 legi	strar's Signature	barle				

06-02742 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Catherine Mary, Hermann

	1- For State Registrar	(	Certificate of	Death		Re	eg. No. 201	16 1791
Physician						Date of Deat     Month	th Day Year	3. Time of Death
ledical Examine	Catherine Mary 4a. Facility Name (if not institution				1	April 22, 2	006	2035 hrs
	2331 East Madison S		4	Baltimore	r Location of De City	eatn	4c. County of Deat	h
Funeral	5. Social Security Number	6. Sex 7. Age (In )	yrs. last birthday)	If Under 1 Ye		Hrs. 18. Date of Bir	th(MM/DD/YYYY) 9. Bi	rtholace /State or
Director	215-82-5342 - unk			Months Da		Min.	Forei	
	Usual Residence of Decedent	1 W 2A F	44 Yrs.	L		Oct. 2	5, 1961   C	outra y / IVID
any	10a. State 10b. County	10c.	City, Town or Location	n				10d. Inside City Limits
Maryland 28a-f show	MD Princ	ce Georges   L	aurel					1 Yes 2 X No
the Maryland as or 28a-f she	10e. Street and Number			10f. Zip Code		11	0g. Citizen of What Cou	
h the 33 or otifie		ley Court		21144				unk
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.  Int: If iten 27 is marked other than "natural", or items 23a or 28a-f she concern the month of the Maryland International Topic Committeed to the International Property.	11. Mantal Status 1 Never Married 2 M	12. Was Decedent Ever arried Armed Forces?	in U.S. 13. Was			( Specify Yes or No- erto Rican, etc.)	- 14. Race - Ame White, etc.	rican Indian, Black,
er dea	Thever walled 2 w	1 Yes 2 X	No					
ural"	at December 51	rorced If Yes, Give Year or Dates: cify only highest grade complete		Yes 2 X N	o specify: ation (Give kind	of work done	Specify: wh:	
2 hou	Elementary/Secondary (0-12)  tunk 12 17. Father's Name (First, Middle	College (1-4 or 5+)	during mo	st of working life	e. DO NOT use	retired) unk	160. Kind of Business	undustry unk
036 thin 7 ne.	unk 12	unk-	Data Ent	rv			Hospital	
215-0036 be filed within 7 trial Hygiene. rked other than ent, the Medica		Last)		<del>unk</del>	18.Mother's Na	ame (First, Middle, M	<u> </u>	
21215-0036 Juld be filed within 72 h Martial Hygiene. marked other than "n c event, the Medical E						McBurney		unk
ID 21215-00; should be filed within and Mental Hygiene. 7 is marked other that event, the Med T B D C T T B D C T T T D D C T T T D D C T T T D D C T T T D D C T T T D D C T T T D D C T T T D D C T T T D D C T T T D D C T T T D D C T T T D D C T T T D D C T T T D D C T T T D D C T T T D D C T T T D D C T T T D D C T T T T			19b. Mailing 2711	Address (Stre	et and Number Path Abi	or Rural Route Num	nber, City or Town, State	e, Zip Code)
ages I and 2 should be I to th	20a. Method of Disposition	la Shimer, Sister	20b. Place of Disposit	ciii Jei	eet bal	Date	ID ZIZUI	
Baltimore, Moemit. Pages I and 2 Department of Health Important: If item 2 Injury or other traum		n 3 Removal from State	crematory or other	er place)			20c. Location - City of	Town, State
timent riment riment riment y or o	4 Donation 5 X Othe 3 21. Signature of Funeral Service		Metro Crem	tory, In	c. 6/	7/2006	Baltimore, M	D
Baltimo permit. Page Department o Important: injury or ott	Ronald	S. Nade Direct	for Sta	me and Addres <b>te Anat</b>	ony Boa	emation Soc	ciety of MD, I	nc. 299
Physician	Zia. Part I. Enter the disease, or	complications in all cansed the d	eath. Do not enter the	mode of dying	MD 212 g, such as cardia	or respiratory arre	ick Road Bart est, shock, or heart	Approximate Interval
/Medical	failure. List only one cause Immediate Cause (Final disease	on each line.						Between Onset and Death
Examiner	or condition resulting in death)	Due to (or as a consequen	nce of):					
	Sequentially list conditions,	b						
	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequen	ice of):					
led nsit	(Disease or injury that thitiated events resulting in death) Last	Due to (or as a consequen	ice of):					
		d	E O 11 10 1F	16 - 1 1	7 10 10 1		TTI 0056 6/0	
760, ficate be execut g physician and the burial - tra	UNPENDED			,16a-6,1/	7,18,19a-l	o,20a-c,22, <sub>I</sub>	perFH,C856,6/8	3/06 TT
8760, ifficate be ng physici	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of		I death 3	Ectopic pre	gnancy	23d. Date of deliver Month	y Day Year
Box 68 e death certif the attending ed for use as	past 12 months?	4 Pregnant at time	of	er (Specify)		gnanoy	World	Day real
Bo ne dear the a hed fo	past 12 months?  1 Yes 2 No 9 V Uni  Part II. Other significant condit	9 Unknown						
, P.O. Bc		ions contributing to death but i	not resulting in the un	derlying cause	given in Part I.		obacco use contribute to	
S, Fquires en sig	<u></u>					_	2 No 3 Pro	
ords, aw requir nas been s 2 should	<u> </u>					24a, Was autop	sy prior to	utopsy findings available completion of cause of
tal Records, sinn: The law require certificate has been si ector, page 2 should be						1 Yes	med? death? 2 N 1 ✓ Y	es 2 No
ician: The ician: The rector, page		Hospital:			of Death (Che			
of Vital ng Physician: After this certi	27 Manney of Death	28a. Date of Injury	2 ER/Outpatient 28b. Time of In		ury at Work?		Residence 6 Othe	r: Scene
ion of tending Pheath. or: After the funeral	1 Natural 5 Pend	(Month, Day, Year)	FOUND:		Yes 2 V No	UNKNOWN	now injury occurred	
Division tal or Attendir rs after death. al Director: A led in by the fu	2 Accident Inve	stigation Apr 22, 2006	2030 hrs At home, farm, street			28f Location (S	Street and Number or Ru	ural Route Number, City
Division o spital or Attending tours after death. neral Director: After filled in by the fune	3 Suicide 6 ✔ Coul dete	d not be (Specify) Vacant		,	Dananig, oto.	or Town, S	tate) Madison Street, Ba	
Hosp 24 hou Funer tely fi		hysician: To the best of my know		ed at the time, o	date and place, a			
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	one) 2 Medical Exa	miner:On the basis of examinati	on and/or investigation	n, in my opinio	n, death occurre	ed at the time, date	and place, and due to the	e cause(s)
F × F ŏ	29b. Signature and title of certific			29c. Licen	se number		29d. Date signed (Mo	nth, Day, Year)
	ane I			O.C	.M.E.		April 23, 2006	
		who completed cause of death (					<u></u>	
		sistant Medical Examiner			ore, MD 212	201		
Stat	e 31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	and a				

06-03040 HYPC	di	te, Alphonso kenneth Please Type or Print in Black Indelible Ink	
UNK UNK			006 1791
Physicia		Registrar   Registrar   Registrar   Registrar   Registrar   2. Date of Death	3. Time of Death
Medical Exami	-	I Month Day Yea	o946 hrs
R		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of	of Death
		910 North Broadway  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year   If Under 24Hrs.   8. Date of Birth(MM/DD/YYYY)	9. Birthplace (State or
Funeral Director		5. Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I f Under 24Hrs. 8. Date of Birth(MM/DD/YYYY Months Days Hours Min. Apr 26, 1964	Foreign unk
		Usual Residence of Decedent	10d. Inside City Limits
ow any		10a. State 10b. County 10c. City, Town or Location	1 X Yes 2 No
ryland a-f sh	ctor	MD Baltimore  10e. Street and Number 10f. Zip Code 10g. Citizen of Wh	nat Country?
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.  ant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other tranmatic event, the Medical Examiner must be notified at once.	Director	803 Jack Street 21225	unk
h with	Funeral	White	- American Indian, Black, e, etc.
er deat , or itt	Fun	Never Married 2 Married 1 Yes 2 No 1 Yes 2 No specify: Specify: Specify:	1.11
urs aftu tural"	d by	or Dates:	black usiness/Industry
5 72 ho nn "na	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired) unk	unk
003( within giene. ner tha	duc	unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname	A
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	Be C		unk
21; nould to id Men is mar tic eve	To I	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Tow	n, State, Zip Code)
ME nd 2 sl alth ar em 27 rauma		O.C.M.E.   111 Penn Street Baltimore, MD 21201   20a. Method of Disposition   20b. Place of Disposition (Name of cemetery,   Date   20c. Location   20b. Place of Disposition   ity or Town, State	
Ore, ges la of He		1 Burial 2 Cremation 3 Removal from State crematory or other place)	ony or roun, out.
Baltimore, MD oemit. Pages I and 2 sho Oppartment of Health and Important: If item 27 is nijury or other traumat		21 Signature of Funeral State 1	
Balti permit. Departm Importa		21. Signalure of Funeral Scripe Licensee State Anatomy Board 655 W. Balti Baltimore, MD 21201	more Street
Physician		23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he failure. List only one cause on each line.	art Approximate Interval Between Onset and
Medical Examiner		Immediate Cityle (Final disease a. Cocaine intoxication	Death
		or condition resulting in death)  Due to (or as a consequence of):  b.	
	ner	Sequentially list conditions,	
	Examine	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	
ecuted and transit			
O, be ex sician burial	edic		
876 tificate ng phy as the t	W/U	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month	f delivery Day Year
Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/Medical	past 12 months?  4 Pregnant at time of death death death death death line of the cours	
t of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be execute After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - tran	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.	ribute to the cause of death?
P.C es that iigned	d by		Probably 4 V Unknown
rds, requir been s	lete	24a. Was an autopsy 24b.	Were autopsy findings available prior to completion of cause of
eco he law ate has age 2 s	ompleted	performed? 1 ✓ Yes 2 N 1	death? ✓ Yes 2 No
al R ian: T certific	ပ	25. Was case referred to medical 26. Place of Death (Check only one)	
F Vit	To B	1 V Yes 2 No Inpatient 2 EN/Outpatient 3 DOA 4 Nursing Home 5 Residence 6	
Division of Vital Records, P.O. and or Attending Physician: The law requires that the safer death.  "In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ion:	27. Manner of Death    28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   28d. Describe how injury occurred   1 Natural   5 Pending   Find 5/5/2006   Find 0.43 cm   1 Yes 2 X No   Vink   Vi	eu
risic r Atter ter dea irector in by th	ficat	2 Accident Investigation Investigation Suicide 6 X Could not be 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number of Town State) 910 No.	per or Rural Route Number, City Orth Broadway
Div pital o ours afi eral D	Certification:	Suicide 6 X Could not be determined (Specify) vacant house or Town, State) 910 No Baltimore, MD	orth broadway
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical (		
To 1 To 1 com	Med	and manner stated.  29b. Signature and title of certifier  ANA KUBIO TOR  29c. License number  29d. Date sign	ned (Month, Day, Year)
		QUELZ' MARGARITA WORELL O.C.M.E. May 16, 20	006
-		30. Name and address of person who completed cause of death (Item 23a)  Name and address of person who completed cause of death (Item 23a)	
	tate	Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  31. Date filed (Month, Day, Year)  32. Registrar's Signature,	
Regis		A PARAMETER A PARA	

06-03440		Please Type or Print in Black Indelible Ink									
Charles Hood		State of Maryland / Department of Health and Mental H	lygiene	•	2006 179						
		I- For State Certificate of Death	F	Reg. No.	1000 1/9						
Physicia	_	1. Decedent's Name (First, Middle,Last)	Date of De     Month		3. Time of Death						
Medical Examir	ner	Charles Hood	May 21,	Day Yea 2006	1058 hrs						
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	h	4c. County	of Death						
<		3643 Malden Avenue Baltimore City		_							
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	s. 8. Data of B	Birth (MM/DD/YYY)	9. Birthplace (State or Foraign						
Director		215-28-4049 1XM 2F 75 Yrs. Months Days Hours Min		5, 1930	Country) Maryland						
	ŀ	215-28-4049   1×M 2 F   75 Yrs.     Usual Residence of Decedent	JJun 1	J, 1930	Thatyland						
any	ı	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits						
		MD Baltimore			1 X Yes 2 No						
Aaryland 28a-f show	왕	10e. Street and Number 10f. Zip Code	T	10g. Citizen of WI	hat Country?						
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Director	26/2 M-14 A 21211	1	T.C.A							
ith th		3643 Ma1den Avenue 21211  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S)		JSA Ina I 14 Race	e - American Indian, Black,						
ath w	Funeral	1 X Nover Mexical 2 Mexical Armed Forces? If Yes, specify Cuban, Mexican, Puerto			e, etc.						
er de		1 X Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify:	white						
rs aft ural"	5	15. Decedent's Education (Specify only highest grade completed)  16. Decedent's Usual Occupation (Give kind of	work done		isiness/Industry						
hou "nat	ē	Elementary/Secondary (0-12) College (1-4 or 5+)  College (1-4 or 5+)		1.55.74.11.4 51.25	unk						
36 nin 7, than dical	Completed	12 none Laborer									
With Decreption	<u></u>		e (First, Middle	, Maiden Surname	2)						
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Bec	21 1			,						
212 212 212 Menti mark		Lawrence Charles Hood Anna Kat  19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or			vn. State, Zip Code)						
MD 2 nd 2 shou lith and 1 m 27 is r aumatic	-										
and 2	ŀ	Michael Frank/exectutive 3641 Malden Ave. Balt  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date Date	20c. Location	- City or Town, State						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once		1 Burial 2 Cremation 3 Removal from State crematory or other place)			•						
Pag ment tant:		4 X Donation 5 Other Specify:									
Salt ermit epart mpor		21. Signature of Funeral Service Licensee Ronald S. Wade Director State Anatomy Boar	rd 655 I	W. Balti	more Street						
	$\dashv$	Baltimore, MD 2120	)1								
Physician		23a. Party. Enter the disease/or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	or respiratory a	rrest, shock, or he	Between Onset and						
/Medical - Sxaminer		Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease			Death						
1		or condition resulting in death)  Due to (or as a consequence of):									
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sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be er death.  ector: After this certificate has been signed by the attending physicia by the funeral director, page 2 should be detached for use as the buria	Se l	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of	f delivery						
687 ertifi ding	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnant in the	ancy	Month	Day Year						
Box e death c the atten	Sici	4 Pregnant at time of death 5 Other (Specify)									
he de	چ	9 Olikilowii	220 Did	tabases use sont	ribute to the cause of death?						
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S, P uires th n signe d be d	Pa	Diabetes Mellitus									
ords, w requir is been s should	Completed			opsy	Wera autopsy findings available prior to completion of cause of						
e CC ne lav te ha	Ĕ			formed? (c) 2 ✓ No 1	death?						
tal Rection: The Lecting The Lection to Page		25. Was case referred to medical 26. Place of Death (Check		20.10							
lita Sician is cer irecto	Be	examiner? Hospital: 4 Innation: 2 EP/Outpatient 3 DOA Other, Nursing	ng Home 5	Residence 6	✓ Other: Scene						
n of Vital Records, ling Physician: The law requir After this certificate has been s funeral director, page 2 should I	٩	1 ✓ Yes 2 No Impatent 2 Envolupation 3 Don 4 Normalization 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		e how injury occur							
D C	. <u>.</u>	1 V Natural 5 Pending (Month, Day, Year) 1 Yes 2 No									
Sic Sic Atter r dear ector by th	cat	2 Accident Investigation 28e Place of Injury - At home farm street factory office building etc.	28f Location	(Street and Numb	ser or Pural Poute Number City						
Division tall or Attendir is after death.  "al Director: A ted in by the fu	E	Suicide Could not be determined (Specific)									
Spit.											
DIV To the Hospital or within 24 hours afte To the Funeral Dir	<u>S</u>	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred									
Division  To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fur	Medical	and manner stated.  29b. Signature and title of certifier  29c. License number			ned (Month, Day, Year)						
	-	236. Signature and title of certifier		May 31, 20							
				Iviay 51, 20							
_		30. Name and address of person who completed cause of death (Item 23a)	MD 21201								
		Mary Chipple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, N	VID 2 1201								
	ate	31. Date filed (Month, Day, Year)  JUN 0 7 2006  32. Registrar's Signature									
Regist	nen.	JUN 0 1 2000   Registration of the second									

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registra Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Vear 12 35 AM Physician JOHNSON-KENNEDY JUNE 04 LAVINIA 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE N/A JOHNS HOPKING BAYVIEW MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, ) 10/12/ Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 □ F 85 218-12-7882 1920 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a. State 10b County r then "naturel", or iteme 23a or 28a-f show the Medical Examiner must be notified at RANDALLSTOWN BALTIMORE MD 1 ☐ Yes 2X No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21133 3900 RAYTON ROAD death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ZX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 XNo Specify: Specify: δ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+) DOMESTIC HOUSEWIFE 12TH 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill ment of Health and Mental Hisht: If item 27 is marked ott GERTRUDE COOK HERMAN JOHNSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PATRICIA JOHNSON / DAUGHTER 27 DEEP POWDER CT., WOODSTOCK, MD 21163 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ŏ 15€ Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. WOODLAWN CEMETERY 6/9/06 BALTIMORE CO., MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Fineral Service Licensee 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD att. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, pock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** BACTERIAL AND FUNGAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PNEUMONIA Saventially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires thet the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ŏ Month Day Year 4☐Pregnant at time of death signed by the at d be detached fo 5 Other (specify) 1 ☐ Yes 2 No Ö 9 Unknown 9 Unknown σ, 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 ± autopsy performed? 2 No certificete 1 Yes 2 No 1 TYes of Vital Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Division 5 Pending investigation 1 Natural s after dec. 1 ☐ Yes 2 ☐ No M 2 Accident 6 ☐ Could not be 3 🗋 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide To the Hospital or within 24 hours a To the Funeral ( 1/8 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-001 TWAF 05,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVENUE . BALTIMORE ANIL SURYAPRASAD 4940 EASTERN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registra

			5	State of Maryla		rtment of Hea		•	•	17916
		•	For State Registrar			tificate of De			g. No.	
ı	Physicia /Medic		1. Decedent's Name (First, Middle, Last	)		Jor	res 1	Date of Death Month	Day 2 Year	3. Time of Death
•	Examin		4a. Facility Name (If not institution, give	street and number)	14-11	4b. City, Town, or Loc	cation of Death	0:1.	4c. County of De	
	Funeral		5. Social Security Number 6. Se		S. last birthday)		Under 24 Hrs. 8	Date of Birth (Month, Day,	N,	rthplace (State or Foreign
	Director		220-36-9439	⊐м 2ХО ғ 6	4 Yrs.	Months Days F	Hours Min.	06/23	/1941 S.	CAROLINA
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Loc	ation				10d. Inside City Limits
	B Many	ctor	MD N/A	]	BALTIMO	ORE CITY				1X Yes 2 No
	h with th	Funeral Director	10e. Street and Number 2232 W. LEXIN	GTON STREE	Г	10f. Zip Code 21	223	10	g. Citizen of What C USA	Country?
9	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heelih and Mental Hygiene. If Heelih and Mental Hygiene. It wanted other then "natural", or liteme 23s or 28s-f show other traumatic event, Ira Modical Examinar must be notilised at	by Funer	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		/as Decedent of Hispa Yes, specify Cuban, N ☐ Yes 2☐No S	nic Origin? (Speci Mexican, Puerto Ric Specify:	fy Yes or No- can, etc.)	14. Race - Am Black, Wh Specify:	
5	2 hou	ted t	15. Decedent's Edi	ucation	16a. Deced	ent's Usual Occupation	n	1	6b. Kind of Business/Industry	
21712	i within 7 liene. r then "n Ine Med	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	`life. C	tind of work done durir 10 NOT use retired) ECEPTIONI			ST. JAMES CONDOMINIUMS	
ב ב	d be filed intal Hyg ad othe	Be	17. Father's Name (First, Middle, Last)  JAMES OWENS			18.	. Mother's Name (/			
	should and Me s mark umatic	10	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailin	Address (Street and				Zip Code)
ž	and 2 eelth a m 27 is		KELLY D. JONES	/ DAUGHTER		HOLLINS		<u> </u>	<b>.</b>	
	Pages 1 nent of H int: if ite iry or ot		20a. Method of Disposition  1   Burial 2 ☐ Cremation 3 ☐ I  4 ☐ Donation 5 ☐ Other (Specify,	Removal from State		atory or other place) MORIAL PK	Dat 6/10/		0c_ Location - City o	MILL, MD
	permit. Pages Depertment of Important: If i any injury or o		21. Signature of Funeral Service Licens	199 X 11/1	_	Name and Address of	11011			OME 21207 IMORE, MD
			23a. Part Finter the disease, or comp shock, or neert failure. List only of	lications that caused the de- ne cause on each line.	n. Do not ente	r the mode of dying, s	uch as cardiac or r	espiratory arres	St, DALI	Approximate Interval Between
,	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Intrac	abdon	ninal o	Sepsi	S		3 WEEKS
	Examiner	_	Sequentially list conditions,	b. bowel p	erfore	fion				Imonth
/	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. mitral v	alve re	placeme.	nt			14 month
,007	te be executed ysicien and e burial-transit	cal Ex	resulting in death) Last	Due to (or as a conse d. Lndoca.		•				2 month
00 X	entificat ling ph) e as th		IF FEMALE:	220 16 100 01400 01						
.O. DOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours attended ath. To the Funeral Director: After this certificate has been signed by the ettending physicien and To the Funeral Director. After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, pege 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 wonths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of de Month	Blivery Day Year
Colds, r	uires thet signed b id be deta		Part II. Other significant conditions co		esulting in the un	derlying cause given in	n Part I.		cco use contribute	o the cause of death?
200	law req as been 2 shou	Completed by	Theumatic h	•—				24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
מ ופווי	n: The ficete h or, pege	e Con	25. Was case referred to medical				- C	perform 1 ☐ Yes 2	ed? death? No 1 ☐ Ye	1.6
	iysicia iis cert direct	To Be	examiner?	Hospital: 1 Inpatient 2	☐ ER/Outpatient	Other	<ol> <li>Place of Death (6</li> <li>Wursing Home</li> </ol>		ce 6 □Other (Sp	ecify)
5	iding Pt th. : After th funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes	2 No	d. Describe how	v injury occurred	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		et, factory, office	28	f. Location (Stre City or Town,	eet and Number or F State)	dural Route Number,
	Hospita 24 hours Funeral	Medical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	rsician: To the best of my kr iner: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at the time, o	date and place, and on, death occurred	d due to the cau at the time, dat	use(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	and marrier states.		29c. License nu	ımbər	296	d. Date signed (Mor	th, Day, Year)
	,		> Kelly Uli	in MD		RES-	600	7	Tune 2,	2006
	11		30. Name and address of person who co				Balkmon	· MD	21287	
į	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature A	d's				
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No:--1. Decedent's Name (First, Middle, Lest) 2. Date of Death **Physician** 25 May William F. Junker 2006 7:35 PM /Medical 4b. City, Town, or Locetion of Death 4a. Fecility Name (If not institution, give street end number) 4c. County of Death Examiner 17313 Mountain View Road Emmitsburg Frederick if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yes Jan 18, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral <sup>Year)</sup>1950 Pennsylvania Deys 1 M 2 □ F Yrs. 205-40-7048 56 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or items 23a or 28a-f show Examiner r-wat be notified at MDFrederick Emmitsburg 1 Nes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene.
Int: If item 27 is merked other then "neturel", or items 23a or 2 ry or other treumatic event, the Medical Exacuret must be not 17313 Mountain View Road 21727 USA Funeral 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify. white Specify: Ď 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager Publishing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William C. Junker Frances Libell ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 17313 Mountain View Rd. Emmitsburg, MD 21727 Linda Junker, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or \$mithsburg Crematorium 5-31-06 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. L. Davis Funeral Home 12525 Bradbury Ave., Smithsburg, MD 2178B ntering disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, rheart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Metastatic Squamous Cell Cancer 2 years Examiner Immune Sappression 16 years Physician/Medicai Examiner end I-transit The law requires that the death certificete be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Kidney-Pancreas Transplant 16 years ettending physician e for use es the buriel-Division of Vital Records, P.O. Box 68760, Kidney (oras consequence of) After this certificate has been signed by the fundreal director, page 2 should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? History of Type Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was en eutopsy performed? 1 ☐ Yes 2 HNo 1 ☐ Yes 2 ☐ No or Attending Physicien: 25. Wes case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ XNo 27. Menner of Death 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending efter death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide 24 hours 152 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To the within 2 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) **B**0044037

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Registrar

J.

Bonita

DO Portier, 32. Registrar's Signature

30. Neme and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

Krempel-

June 07, 2006

21727

121-123 W. Main St. Emmitsburg, MD

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygien [ ] Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **JACOBS** Year **Physician** JUNE 5, 2006 7:30P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 9010 PHILADELPHIA ROAD ROSEDALE BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 8-5-1922 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1₩ M 2□ F 83 Yrs. OKLAHOMA 440-16-1722 Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avent. The Medical Examinar must be notified at 1 ☐ Yes 2X No ROSEDALE BALTTMORE Director MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21237 U.S.A. 9010 PHILADELPHIA ROAD death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after w Health and Mental Hygiene. 9m 27 Is marked other then "natural", or Iter 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: WHITE þ Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates:1940-50 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SELF PLUMBER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **JACOBS** MARY FLIZABETH (WHITEHEAD) BENJAMIN L. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EVELYN L. JACOBS/WIFE 9010 PHILADELPHIA ROAD ROSEDALE, MD 21237 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ment of H ent: If ite 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department ( Importent: If any injury or 6-9-2006 HOLLY HILL CEMETERY MIDDLE RIVER, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME of Funeral Service Licenses 1211 CHESACO AVENUE ROSEDALE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ances **Physician** MC disease or condition resulting in death) Due to (or as a corsequence of): /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy ormed? No perfor 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X FR/Outpatient 1 🗌 Yes 1 Inpatient Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending death 1 ☐ Yes 2 ☐ No investigation Director 6 Could not be determined 3 Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by filled in by 4 Homicide Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the h 29b. Signature and place of ce 29d. Date signed (Month, Day, Year) rtifier 29c. License number mno 6 6 who completed cause of d (Item 23a) (Type 32 Aegistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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	Physici		1. Decedent's Name (First, Middle, Last	JONES			Date of Death Month	ay 2006	3. Time of Death $\rho$
	/Medic Examin Funeral Director		011-00-3031	street and number) 1 K fo r.d		more	Date of Birth Month, Day, Year	c. County of Dea	th A thplace (State or Foreign Juntry)
	the Maryland 28a-f show cdiffed at	ector	Usual Residence of Decedent  10a. State 10b. County  10e. Street and Number	10c. City, To	own or Location  altimore  10f. Zip Code		100 0	Air-ra of What O	10d. Inside City Limits 1 ▼Yes 2 □ No
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants If item 27 is marked other than *naturel', or Items 23a or 28a-f show may injury or other traumatic event, the Medical Expiritive must be rediffed at once.	by Funeral Director	1536 Pent  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1   Yes 2 No If Yes, Give Year or Dates:	2/23  13. Was Decedent of Hispani If Yes, specify Cuban, Me	Gic Origin? (Specify exican, Puerto Rica	Yes or No-	14. Race - Ame Black, Whit	Anican Indian,
121215-0036	filed within 72 ho Hygiene. other than *naturent, the Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	coation (e completed) College (1-4or 5+)	Sa. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use religed)	ή	Es		Industry  20mm. College
Maryland	should be find Mental Hamarked of	To Be	Waverly	Stokes		Mother's Name (File	Jen	Kins	
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Baltimore,	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Licens		3 Name and Address 13 OSEPH L	Spility F.	uneral Balton	ttome	P.A.
	rnysician /Medical		23a. Part . Enter the disease, or comp shock or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. Done cause on each line.  a. Due to (or as a consequence)	TIA	ch as cardiac or res	spiratory arrest,		Approximate Interval Between Onset and Death
3760,	cate be executed by physician and ithe burial-transit	icai Examiner	S-quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence.  Due to (or as a consequence.	MIC CAR	DIO M	10 PATM	17	
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown				23d. Date of del Month	ivery Day Year
₾.	w requires that been signed b should be deta		Part II. Other significant conditions co	ntributing to death but not resulting	g in the underlying cause given in F	Part I.	23e. Did tobacco		the cause of death?
al Records,	n: The law re licate has bee rr, page 2 sho	Completed					24a. Was an autopsy performed? ! ☐ Yes 2 ☑ No	prior to d	topsy findings available completion of cause of
Division of Vital	*Attending Physician: The Is death. rector: After this certificate ha by the funeral director, page by the funeral director, page.	ation; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Mann of Death Natural 5 Pending investigation	The second second	Other				sify)
Divis	Ital or Atten irs after deat ral Director: led in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)			City or Town, State	ə)	ral Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	(Check only 2 Medical Exami	sician: To the best of my knowled ner: On the basis of examination and manner stated.	and/or investigation, in my opinion,	, death occurred at	the time, date and	d place, and due	to the cause(s)
	5 Wild	-	29b. Signature and title of certifier		29c. License numl			te signed (Month	
	9		30. Name and address of person who co	empleted cause of death (Item 23a	1) (Type, Print) Namet PC	go, Di	mdalk	2.mp	21222
	Sta Registr		31. Date filed (Month, Day, Year)  JUN 0 7 20	32. Begistrar's Signature	Sparke				90 90 10 10 10 10 10 10 10 10 10 10 10 10 10

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	partment of Fertificate of			ene 200	6 1792		
	Dhusia		Decedent's Name (First, Middle, La	st)				2. Date of Death Month	Day Ye	3. Time of Death		
	Physic /Medi		ROBERT JONES SR					June	200			
	Exami	ner	4a. Facility Name (If not institution, give			_	or Location of Death		4c. County of D	1		
			Franklin Squa	re Hos	Pital	Rose				timore		
	Funeral Director		5. Social Security Number 6. S	7. Ag	je (In yrs. last birthda) 69 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day 3 6-5-193	(ear) 9.	Birthplace (State or Foreigr IARY LAND		
			Usuel Residence of Decedent					0 3 130				
	rylan		10a. State 10b. County		10c. City, Town or I					10d. Inside City Limits		
	Ba-f	cto	MD. N/A		BALTIMO	ORE				1 X Yes 2 No		
	with th	Director	10e. Street and Number	DIACE ADT	· II	10f. Zip Code 2122	0.1	10g	J. Citizen of What	Country?		
	death with the Maryland me 23a or 28a-f show rmast be notified at	by Funeral	702 PINE BRANCH	12. Was Decedent					USA			
	fer d	Ē	11. Marital Status 1 □ Never Married 2 → Married	Armed Forces?	No		lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Black, W	merican Indian, /hite, etc.		
Š	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1☐ Yes 2☑No	Specify:		Specify:	BLACK		
+ 5	72 ho	Completed	15. Decedent's E (Specify only highest gra	ducation	16a. Dec	edent's Usual Occup	pation	16	b. Kind of Busine	ess/Industry		
6	ighi e	du	Elementary/Secondary (0-12)	College (1-4or !	5+)		during most of worki d)	ing		2.27.5		
9	CLEID-UUSO filed within 72 hours after Hygiene. sther than "netural", or Ite ant, the Medical Examina	S	17. Father's Name (First, Middle, Last,	-0-	51	CURITY	40 14-4-4-14	(F) 1 A(1) N A(	GIANT F	OODS		
Rober	if e) INTEGRATION INTEGRATIONS IN THE MAIN INTEGRATION INTO A STAND INTEGRATION INTO A STAND INTEGRATION INTEGRATI	To Be	NORMAN JONES				JESSIE	(First, Middle, Ma. JONES	iden Surname)			
~	2 sho		19a. Informant's Name/Relationship (				and Number or Rura					
	DESILITIONE, Mispermit. Pages 1 and 2 Depertment of Health a Importent: If them 27 is eny Injury or other tra-		NORMA JONES (DAU) 20a. Method of Disposition	GHTER)	433	4 PLAINFI	ELD AVE.					
one	Dattimore, Dermit. Pages 1 ar Depertment of Hea mportent: If them any injury or othe		1 ⊠ Burial 2 ⊈ Cremaylon 3 □	Removal from State	cemetery, cre	osition (Name of amatory or other place	ce)	ate 20	c. Location - City	or Town, State		
0	it. Partituder ritent		4 Donation 5 Other (Specif		GLEN HAV	EN MEM. P	ARK   6-9-2	006 GI	EN BURN	IE, MARYLAND		
n	Dall permit. Depert Import eny Inj		21. Signature of Europeal Service Lices	MAHTANOE								
1			23a. Part / Enter the disease, or com	plications that caused						RYLAND 21217 Approximate		
	Dhysisian		23a. Part / Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each li	ne.		9, 550, 45 54, 614, 6	rospiratory arrost		Interval Between Onset and Death		
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	a consequence of):							
	Examiner			. Card	i C C A	crest						
1		Jer	Sequentially list conditions, in a cause. Enter Underlying Cause (Disease or injury									
	and I-transi	Examiner	that initiated events	c.								
032	te be executed ysicien and he burial-transit		resulting in death) Last Due to (or as a consequence of):									
0770	0 00	dical		d						-		
3	Attending Physicien: The law requires that the death certificat redath.  Totash.  story After this certificate has been signed by the ettending phy the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy							
ď	eath certif ettending for use a	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of o Month	delivery Day Year		
C	by the tached	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	5. 554.11	Other (specify)						
٥	s thet	y P	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the (	underlying cause give	en in Part I.	23e. Did tobac	co use contribute	to the cause of death?		
Ţ	w requires the	ed						1 XYes	2 No 3	Probably 4 Unknown		
3	has be	piet						24a. Was an	24b. Were	autopsy findings available		
à	The The Sete has page	Completed						autopsy performed	death	o completion of cause of es 2 \sum No		
	vicion: The certificate	Be (	25. Was case referred to medical examiner?				26. Place of Death		140 121	63 20140		
5	Physic this o	၉	1 ☐ Yes 2 No	Hospital:			4   Nursing Hon	ne 5 🗆 Residence	a 6 ⊡Other (Si	oecity)		
}	ding P	on:	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Mate of Injur (Month, Day	y Year) 28b. Time o	Work		8d. Describe how i	njury occurred			
.5	Mitendi death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No					
obygon of Wiving Decorated	after after Direct d in by	Certification:	4 Homicide determined	building, etc	ury - At home, farm, st c. (Specify)	reet, factory, office	2	8f. Location (Stree City or Town, S	t and Number or tate)	Rural Route Number,		
	To the Hospitel or Attency within 24 hours after death To the Funerel Director: completely filled in by the	ledical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best on the passe of and manner sta	of my knowledge, dear examination and/or in	th occurred at the tim	ne, date and place, a pinion, death occurre	nd due to the cause od at the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)		
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	and mailing Sta		29c. License			Date signed (Mo			
	r s r o		The		-	7	62211	1				
	1. 1	,	30. Name of pirson who	completed c use of de	eath (Item 23a) (Type,	Print)	63216		5-1	2006		
					Square D	rive Ba	63216 Itimore	Maryla	nd 21	237		
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature							
	Registr	ar	JUN 0 7 2006	Been	OF Beach	J.						

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and N  1- State Senistrar  Certificate of Death		- 211116	17921
	Dhysisi	200	Registrar  1. Decedent's Name (First, Middle, Last)	Reg.  2. Date of Death  Month		3. Time of Death
2	Physici /Medio	al	4a_Facility Name (If not institution, give street and number)  4b. City. Town, or Location of Death	5-3	4c. County of Death	1.04pm
	Examir	ier	Good Sameritan Hospital Bultimor	e		
	Funeral Director		5. Social Security Number 6. Sex 1 M 20(F) 7. Age (In yrs last birthday)   If Under Y Year   If Under 24 Hrs.  North Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthplai Country	(State or Foreign
	land bw		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		100	I. Inside City Limits
	ith the Marylar or 28a-f show	ctor	MD Baltimore			1. Yes 2 □ No
	death with the Maryland ms 23a or 28a-f show rmust be notitied at	Funeral Director	106. Street and Number  4509. F. 15080. A. 20 Muse. 21214	10g.	Citizen of What Country	y? —
	after death or Items 2 miner mun	unera	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - American Black, White, etc	
<b>9036</b>		by	1 Never Married 2 Married  1 Yes 2 No If Yes, Give Year or Dates:  1 Yes 2 No 1 Yes 2 No Specify:		Specify: Bl	o ik
7/19 215-0036	in 72 hours n "natural", dedical Ex	Completed	15. Decedent's Education (Specify only highest grade completed)  [Second of work done during most of work life, DG NOT use retired)	king 16b	. Kind of Business/Indu	stry
6 2	filed within Hygiene. wher than "	Com	Elementary/Secondary (0-12) College (1-4or 5+)  Wurse  19. Matheda Name (5) of Middle (ant)	ne (First, Middle Maio	tealth (	are
Z land	2 should be filed within and Mental Hygiene. Is marked other than aumatic evant, the M	To Be	17. Father's Name (First, Middle, Last)  18. Mother's Nam  (40)	ille 2	eed	
S S Mary			19a. Inform nt's Name/Relationshin (Type, Print)  19b. Mailing Address (Street and Number or Rui		ty or Town, State, Zip C	ode)
17 6	es 1 and of Health fitem 27 r other tr		20a. Method of Disposition 20b. Place of Disposition (Name of cameters, crameters, or other place)	Pate Oc.	Location - City or Town	n, State
101 Baltimor	permit. Pages Department of Important: If it any injury or o		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	1 0	ungsMill	s, MI)
B	permit. Departimport. any inj.	la la	Eun M. Sie Yach ? Look ?	1. Belto	MDZIZI	2
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	or respiratory arrest,	l Ir	pproximate nterval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	u.		
	Examiner	e.	Coquentially list or uniforms, if any, leading to immediate  Due to (or as a lov sequence of):	e Svo		
1	be executed ician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	Cone	2-1-	
760.	ate be executed sysician and he burial-transit	ical Ex	Due to (or as a consequence of):			
99 ×	entificat ling phy se as thi		IF FEMALE: 23c. If yes, outcome of pregnancy			
Division of Vital Records. P.O. Box 68	death co	by Physician/Med	in the past 12 months?    Diversity   1   Versity   1   Ve		23d. Date of delivery Month D	ay Year
P.O	hat the od by the detache	Phys	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	cause of death?
Sp	w requires that been signed to should be deta	ed by	Wassting/expense w loss			oly 4 DUnknown
eco.	e law re has bee	Completed	d'antroco	24a. Was an autopsy performed	24b. Were autops prior to comp death?	y findings available pletion of cause of
<u> </u>	an: Thi tificate tor, pag	Be Cor	25. Was case referred to medical 26. Place of Dea	1 ☐ Yes 2 ☐	No 1 ☐ Yes 2	□ No
j.	hysici this cer al direc	2	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 DER/Outpatient 3 DOA Other: 4 Nursing Hospital:	ome 5 Residence	e 6 □Other (Specify)	
ion	nding F ath. r: After e funer	ation	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury 8b. Time of Injury Work? 1 Yes 2 No	28d. Describe how in	njury occurred	
Sivis	or Atte ifter dea Directo in by th	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St	t and Number or Rural F tate)	Route Number,
_	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the ettending phycompletely filled in by the funeral director, page 2 should be detached for use as the	edical Co	29a. Certifier  (Check only 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur	, and due to the cause	e(s) and manner as state	ed.
	ithin 24 o the F omplete	Medi	one) and manner stated.  29b. Signature and title of certifier 29c. License number		Date signed (Month, Da	
	⊢ s ⊢ ŏ		1 S. Seath MD D50296		6/2/06	5
-	V		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SMASTINE ASSATE 7004 SECURITY BLUI	57=10	OL BAL	TMA
I	St Regist	ate	31. Date filed (Month, Day, Year) 32. Registar's Signature		6	21244
	negist	rai	PROSERVE SO APPENDE			' 7

		-	1 - For State of Maryland / Department of Health and Mental I Certificate of Death	Hygiene 2006 17922
	Physicia /Medic Examin	al -	4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	Day Year 1 2 0 D.
	Funeral Director		216 68 4933 12m 20 51 Yrs. 2-1	f Birth (, Day, Year)  9. Birthplace (State or Foreign Country)  Maryland
	the Maryland 28a-f show	rector	Usual Residence of Decedent   10a. State	10d. Inside City Limits 1 to Yes 2 □ No 10g. Citizen of What Country?
36	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Heath and Mental Hygiene. Important: If them 27 is marked other then "natural", or items 23s or 28s-f show eny injury or other traumatic event, the Madical Examination and page.  90.00.	by Funeral Directo		United States  14. Race - American Indian, Black, White, etc.  Specify: White
21215-0036	d within 72 hours plene. In then "naturel" the Medical Ex	Completed b	3 Widowed 4A Novorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12)  12 years  Year or Dates:  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Maintenance	16b. Kind of Business/Industry  TRucking
Maryland ?	could be filed Mental Hygnarked other hatic event,	To Be C	William L. Kirby, Sr.  Delores Simmon	ddle, Maiden Sumame) 1S
ore, Mar	jes 1 and 2 sh of Health and if item 27 ie n or other traum		19a. Informant's Name/Relationship (Type, Print)  William L. Kirby, Sr. (father)  19b. Mailing Address (Street and Number or Rural Route No. 1611 Marshall St. Baltimore 1611 Marshall St. Baltimore 1612 Marshall St. Baltimore 1613 Marshall St. Baltimore 1614 Marshall St. Baltimore 1615 Marshall Marshall St. Baltimore 1615 Marshall Marshal	e, MD 21230 20c. Location - City or Town, State
Baltimore,	permit. Pag Department important: eny injury once.		4 Donation 5 Other (Specify)  21. Signature of Foural Service Licensee  J. Wayne Osterling  Bayview Crematory 6-7-2006  22. Name and Address of Facility McCully-Polyniak Funeral 130 E. Fort Ave. Baltimo	Baltimore, MD L Home, P.A ore, MD 21230
8760, <	eath certificate be executed  Examineding physician and tor use as the burial-transit  Tor use as the burial-transit  Torse as the b	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Sacva Decubity Ucer, Leg  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Approximate Interval Between Onset and Death Spentershoter 6 week  Wice Months  Years
P.O. Box 6	law requires that the death certific as been signed by the attending p 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Date of delivery Month Day Year
	w requires that been signed b should be deta			Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
of Vital Records,	en: The law itilicate has be or, page 2 sh	e Completed by	25. Was case referred to medical / 26. Place of Death (Check o	
ion of Vi	To the Hospital or Attending Physicien: The Within 24 hours after death.  To the Funeral Director: Alter this certiticate ha completely tilled in by the funeral director, page	To B	examiner?  1   Yes 2   No	Residence 6 □Other (Specify) ribe how injury occurred
Division	Hospital or Atta 24 hours after de Funeral Directo tely tilled in by th	i Certification:		on (Street and Number or Rural Route Number, r Town, State)
	To the Hosp within 24 ho To the Fund completely t	Medical	29b. Signature and title of certifier 29c. License number	
	Sta Registr			imare, MD 2/201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death ne (First, Middle, Last) **Physician** O<sup>4</sup> /Medical 4c. County of Death B. City. own, or Location of Death Name (If not iristitution, give street and number) Examiner 8. Date of Birth (Month, Day, Year) 04/12/1940 Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday) Year **Funeral** 1 ☐ M 2 🗶 F Yrs. 66 Director 220-38-8006 MDUsual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits worke r then "natural", or items 23a or 28a-f ehov the Madical Examinar must be notified at 1 DXYes 2 □ No Director MD BALTIMORE 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 1412 E. LAFAYETTE AVE. 21213 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK Specify. ð 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12TH COOK RESTAURANT and Mental Hygier is marked other ti other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be FRANK JOHNSON MATTIE SAMPLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 MATTIE LANE 2311 HOMEWOOD AVE., BALTIMORE, MD 21218 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ment of I-tent: if its 1 Deurial 2 □ Cremation 3 □ Removal from State ō Depertment of importent: if eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) TRINITY CEMETERY 06/09/2006 BALTIMORE, MD 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Service Licenses 2007-09 EASTERN AVE., BALTIMORE, MD21231 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only cause on each line. the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed attending physicien and for use as the burial-transit .O. Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ned by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown ۵ litions contributing to death but not resulting in the underlying cause given in Part I. Panil. Other significant co 23e. Did tobacco use contribute to the cause of death? Records, signt 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Completed by certificete has blirector, page 2 s Be Medical Certification: To After thi after death.

I Director: Af

1 Yes 2. 100

27. Manner of Death

29a. Certifier

25. Was case referred to examiner?

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

autopsy performed 1 ☐ Yes 20 N 26. Place of Death (Check only one)

Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) and manner stated. 29b. Signature a

29c. License number

29d, Date signed (Month, Day, Year)

State Registrar

7 2006 JUN 0

within 24 hours a
To the Funerel C
completely filled

Division of Vital or Attending Physicien:

lathan Alexander	Kristman
	1- For State

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

2006 1792	200	6 1	15	12
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		Registrar	Death		No.						
Physicia edical Exami	ner	1. Decedent's Name (First, Middle,Last) Nathan Alexander Kristman		May 27, 20	Day Year 06	3 Time of Death 0247 hrs					
		4a Facility Name (if not institution, give street and number) 645 Knights Island Road, Glen 9, Lot 45	4b. City, Town, or Location of Death Earlville	1	4c. County of Death Cecil						
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs last birthday)  160 – 74 – 3164 1 X M 2 F 14 Yrs	If Under 1 Year If Under 24Hrs Months Days Hours Min	_	Foreign						
_		Usual Residence of Decedent				10d Inside City Limits					
ith ihe Maryland 23a or 28a-f show any notified at once.		10a. State 10b. County 10c. City. Town or Locat PA Delaware	Glenolde	'n		1 X Yes 2 No					
Marylar	Director	10e. Street and <b>N</b> umber	10f. Zip Code		g. Citizen of What Count	ry?					
th the 23a or notifie		229 S. Chester Pike, Apt. 37  11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	19036 as Decedent of Hispanic Origin? (S	pecify Ves or No-	USA 14. Race - Americ	an Indian Black					
death w	Funeral		es, specify Cuban, Mexican, Puerto		White, etc.	arr indian, olask,					
s after c	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 X No specify	work done	Specify: Wh	ite					
72 hour "natu	eted		ost of working life. DO NOT use ret		TOD. KING OF OUSITIESS/III	dustry					
0036 within iene er thar	Completed	8	Student	e (First, Middle, Ma	Educati	on					
21215-0036 Juld be filed within 7 Mental Hygiene marked other than ic event, the Medica	Be Co	17. Father's Name (First, Middle, Last) Richard Kristman									
D 21 should b and Mer 7 is mar	٩		g Address (Street and Number or Knights Island R								
e, MD I and 2 sho Health and item 27 is	ŀ	20a. Method of Disposition 20b. Place of Dispos			20c. Location - City or T	-					
MOr Pages nent of ant: If or other					Springfield	, PA 19064					
Baltimore, MD 21215-0036  pepmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene inpraranct of Health and Montal Hygiene inprarate. If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other transmatic event, the Medical Examiner must be notified at once.		1 Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Ho 3111 Mountain Rd., Pasadena, MD 2112									
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	he mode of dying, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and					
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):				Death					
(m. )	L	Sequentially list conditions, bb.									
0	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated									
executed -		events resulting in death) Last  Due to (or as a consequence of):  d.				·					
Jagara es	an/Medical	UNPENDED AMENDED			_						
68760, certificate be ading physici	M/us		etal death 3 Ectopic pregn	ancy	23d Date of delivery  Month Da	ay Year					
Box (e death ce the attended for use	sici	Prognant at time of death	ther (Specify)								
, P.O. Box 687 res that the death certifi signed by the attending be detached for use as t	by Phys	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I		acco use contribute to the						
ords, P				24a Wasar	24b. Were auto	opsy findings available					
SCOF te law ra te has by ge 2 sho	Completed			autops perform 1 ✓ Yes 2	ned? death?	mpletion of cause of					
Vital Reco ysician: The law his certificate has director, page 2 s	a)	25. Was case referred to medical	26.Place of Death (Check								
Vita hysicia this ca I direc	o B	examiner?  1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatien			Residence 6 🗸 Other	Scene					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funerat Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	ertification: T	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  28a. Date of Injury 28b. Time of FOUND: Day, Year) May 27, 2006  1 May 27, 2006  28b. Time of FOUND: Day, Year) May 27, 2006	Injury 28c. Injury at Work?  1 Yes 2 ✔ No	28d Describe ho Subject shot	ow injury occurred						
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	rtifica	3 Suicide 6 Could not be	et, factory, office building, etc.	or Town, Sta	reet and Number or Rurate) Island Road,Early						
Hospita Hospita 24 hours Funera	O	4 V Homicide (Specify) Mobile Home  29a Certifier (Check only) Certifying Physician: To the best of my knowledge, death occur	rred at the time, date and place, an								
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated		at the time, date a							
	Σ	29b Signature and title of certifier	29c. License number O.C.M.E.		29d Date signed (Moniting May 28, 2006	in, Day, rear)					
5		30. Name and address of person who completed cause of death (Item 23a)									
·		Patricia Aronica-Pollak MD. Assistant Medical Examiner  31. Date filed (Month, Day, Year) . 32 Registrar's Signature	111 Penn Street, Baltimo	re, MD 21201							
S Regis	tate trar	31. Date filed (Month, Day, Year) 32 Registrar's Signature	k)								

			_ State	ype or Print i item 8 per State of Mary		delible Ink. 6-7-06 artment of F		All Copies Mental Hy	Are Legible.	17925
	Physici		1. Decedent's Name (First, Middle, Last) HENRY			(LEINMAN	<i></i>	2. Date of De Month	Day Year	3. Time of Death
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give LEVINDALE HEBREW 5. Social Security Number 215-14-9648	HOME 7. Age (Ir	yrs. last birthday 5 Yrs.	BALTIMO	ORE If Under 24 Hrs Hours Min	th	4c. County of Dea	th N/A  Thplace (State or Foreign ountry)  MD
	Maryland f show	or	Usual Residence of Decedent  10a. State 10b. County BALTIMO	1	c. City, Town or L BALTIMO					10d. Inside City Limits
	th with the 1 23a or 28a-	Funeral Director	10e. Street and Number 7 SLADE AVENUE #5	22		10f. Zip Code 21208	3		10g. Citizen of What C	ountry?
2-0036	filed within 72 hours after death with the Maryland Hygione. ther then Insturel', or Items 23a or 28a-f show int, it e Madical Examiner must be mailled at	by	11. Marital Status  1 ☐ Never Married 2 Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates:	MW II	Was Decedent of H If Yes, specify Cub. 1 ☐ Yes 2 🕅 No	Hispanic Origin? (San, Mexican, Puer Specify:	Specify Yes or Norto Rican, etc.)		
1215-0	within 72 ho ene. then "netur re Madical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	edent's Usual Occup e kind of work done DO NOT use retired RIETOR	oation during most of wo d)		16b. Kind of Business	VIndustry  ENGINEERING
Maryland 2121	should be filed and Mental Hygis s marked other umatic event, II	To Be Co	17. Father's Name (First, Middle, Last) MAX	•	INMAN	XILION	18. Mother's Na		e, Maiden Sumame)	COHEN
	nd 2 shot alth and N 27 is ma r treuma		19a. Informant's Name/Relationship (T) SHIRLEY KLEINMAN		19b. Mail 7 SL	ing Address (Street ADE AVENU	and Number or R JE #522 -	ural Route Numb - BALTIM	per, City or Town, State, ORE, MD 212	Zip Code) 108
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel, or Items 23a or 28a-f show any injury or other treumatic event, If a Maryled Examine mast be invilled at once.		20a. Method of Disposition  1 X Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licens	Removal from State	CHIZUK A	MUNO CONO 22. Name and Addre	G 06/ ess of Facility S(	OL LEVIN	BALTIMORE SON & BROS. PIKESVILLE,	, MD
	The law requires that the death certificate be executed  X  X  All has been signed by the attending physician and angle of a should be detached for use as the burial-transit	edical Examiner	resulting in death) Last	Due to (or as a co	PY AR 7 insequence of): INTIA insequence of):		DISEA		arrest,	Approximate Interval Between Onset and Death
O. Box 68760,	ne death certificate the attending physic the attending physic thed for use as the the the the the the the the the the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 Live birth 2 C 4 Pregnant at time 9 Unknown	Fetal death 3	□Ectopic pregnanc; □ Other (specify) _	у		23d. Date of de Month	olivery Day Year
ords, P.O.	w requires that the de been signed by the a should be detached f	b	Part II. Other significant conditions co		ot resulting in the	underlying cause gru	ven in Part I.		tobacco use contribute t	o the cause of death? robably 4 [Unknown
Division of Vital Records,	hyslcian: The law r his certificate has be I director, page 2 sh	e Completed	RECURRENT URIN	ARY TRA	CT INF	ECTION		1 ☐ Yes	prior to death?	utopsy findings available completion of cause of s 2 No
5	s cert	To Be	examiner?	Hospital:	2 ☐ ER/Outpatie	ent 3 DOA Ott		ath (Check only	one) idence 6 □Other (Spe	acifu)
ion of	<u> </u>		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time	of 28c. Injur			how injury occurred	ony
DIVİ	To the Hospitel or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S		treet, factory, office	Harrier Total		(Street and Number or Ri wn, State)	ural Route Number,
	To the Hospitel within 24 hours a To the Funeral ( completely filled	Medical			amination and/or is				cause(s) and manner a date and place, and du	
•	To t To t	Σ	29b. Signature and title of certifier  H. W.C.	westerno		29c. Licens	3327		29d. Date signed (Mon. 06/05/2	,
1	D		30. Name and address of person who co	empleted cause of death					.4.1 0.15	
	Sta Regist		GIZAW WOLDEH 31. Date filed (Month, Day, Year) JUN 0 7 20	32. Egistrar's	Signature —	RE AVE	BALT	IMORE,	MD 212	.1.5
DH	MH 17 Rev 1/2		2018 0 1 70	J. C. C. C. C. C. C. C. C. C. C. C. C. C.	~ 7					

Mleinman, Henry

			1 - For State of Ma	ryland / Depa	artment of F			iene <sub>eg. No</sub> 2006	17926
1	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	th Day Year	3. Time of Death
(4) (6) (6) (6) (6) (6) (6) (6) (6) (6) (6	/Medio	cal	ELIZABETH	BUTLER LEG			June 2	-	9:15 A M
j,	Examin	er	4a. Facility Name (If not institution, give street and number) Heartlands at Severna Par	k		or Location of Death rna Park		Anne Aru	
0	Funeral Director	QL:	5. Social Security Number 6. Sex 7. Age 135-01-3748 1 □ M 2 ☑ F	(In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov 2,	Year) 9. Bii 1911 Ne	thplace (State or Foreign ountry) w Jersey
- E	<b>T</b>		Usual Residence of Decedent				NOV Z,	IJII NE	Ţ
	Marylar Iled	tor	New Jersey Ocean	10c. City, Town or Lo		anchester			10d. Inside City Limits 1 ☐ Yes 2 X No
	with the a or 28g	Director	10e. Street and Number 6B Gramercy Lan	ie	10f. Zip Code	08759	1	0g. Citizen of What C	ountry?
	death me 23	Funeral	11. Marital Status 12. Was Decedent E	ver in U.S. 13.	Was Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	USA 14. Race - Am	
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merall Hyglene. Department of Health and Merall Hyglene. Department: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f show any injury or other treumatic event, the Maralcal Examinational be multified at page.	by	Armed Forces?  1 Never Married 2 Married 1 Yes 2 N.  3 Widowed 4 Divorced Year or Dates:	o	1 ☐ Yes 2 ☑ No		Hican, etc.)	Specify: V	ne, etc. Nhite
2-0	72 hou natura	eted t	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	pation during most of work	ing 16b. Kind of Business/Industry		
21215-0036	within plene. r than "	Completed	Elementary/Secondary (0-12) College (1-4or 5-	-)		during most of work d)		Housewife	& Mother
Maryland 2	d be filed intal Hyg ed other: event,	Be	17. Father's Name (First, Middle, Last)			Name (First, Middle, Malden Sumame) Snus McCree			
ary	should ind Me ind mark	70	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street			, City or Town, State,	Zip Code)
Ž	and 2 saith a n 27 to		Suzanne Alexander (Daught	M		Severna	Park, Ma	ryland 2	21146
ore	ges 1 t of Ho If Iter or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State	20b. Place of Dispo cemetery, crea Mt. Olive	matory or other place	ce)		20c. Location - City or	
altimore,	nit. Pa artmen ortant: Injury B.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee Kevin E			, New Jersey			
å	Dep Per Purp Purp Purp Purp Purp Purp Purp Pur	1 1		., Balto		1225-1856			
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	he death. Do not en	ter the mode of dyir	1 0			Approximate Interval Between Onset and Death
1827	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a	lure		days			
	Examiner	_	Sequentially list conditions, if any, leading to immediate Due to (or as a						0
./	nsit	Examiner	Cause (Disease or injury	consequence of):					
o,	s be executed sicien and burial-transit		that initiated events resulting in death) Last C. Due to (or as a	consequence of):					
68760,	icate be physici s the bu	dical	d						
Box (	eath certifica attending pt for use as t	an/Me	IF FEMALE: 23b. Was decedent premant 1□Live birth 2		Dectopic pregnancy	v		23d. Date of de	*
о. П	res that the death certific igned by the attending p be detached for use as	Physician/Med	in the past 12 months? 1 ☐ Yes 2 (UNo 9 ☐ Unknown 9 ☐ Unknown		Other (specify)			Month	Day Year
ds, P	The law requires that the death certificate be executed tie has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	þ	Part II. Dther significant conditions contributing to death but	not resulting in the u	nderlying cause giv	ven in Part I.		oacco use contribute to	the cause of death?
Records,	sw requir s been si s should	olete	per cheral news	-ocati	res		24a. Was ar	n 24b. Were a	utopsy findings available
al Re	ysician: The lav is certificate has director, page 2 :	Completed	perigine actions		0		autops perform 1 Yes 2	y prior to	completion of cause of
Vital	sician: Th certificate irector, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ M6 Hospital: 1 ☐ Inpatien	t 2 ☐ ER/Outpatier	Oth	26. Place of Death			Assisted
ס ר	Attending Physician: r death. ector: After this certifice by the funeral director, p	n: To	27. Manny of Death 28a. Date of Injury		IL 3LI DOA	4   Nursing Ho		nce 6 No her (Spe w injury occurred	city) LI VIII
Sior	Attending Ph or death. ector: After th by the funeral	catio	2 Accident investigation	7 Sury mijury		Yes 2 □ No			
Division of	s after d s after d el Direct ed in by	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injurbuilding, etc.	y - At home, tarm, str (Specify)	eet, factory, office		28t. Location (Str City or Town	reet and Number or R , State)	ural Route Number,
	To the Hospitel or Attenwithin 24 hours after deall To the Funerel Director: completely filled in by the	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state	examination and/or in	h occurred at the tir vestigation, in my o	me, date and place, ppinion, death occurr	and due to the ca ed at the time, da	tuse(s) and manner a ate and place, and due	s stated. e to the cause(s)
- 8	To th within To th	Me	29b. Signature and title of certifier	. N	29c. Licens	se number	29	9d. Date signed (Mont	h, Day, Year)
	i		30. Name and addr. s of par on who completed cause of de	ath (Item 23a) (Type	Print)	0125	6	0-2-	X006
	Q	- 11	Jenniter Kiedinger St	Ol Vete	cansti	vy Mil	lorsvill	e MD	31108
	Sta Registr	_	31. Date filed (Month, Day, Year) 32. Registral	S Signature	20	U			

DHMH 17 Rev 1/2001

			For State Registrar	State of I	Maryland /		artmen rtificate			and M	F	Reg. No.	006	1792	7
	Physicia		1. Decedent's Name (First, Middle	1 0 1.0	phari	n					2. Date of Dea Month	Day	year 2006	3. Time of Death  9 00 P	М
	/Medic Examin		4a. Facility Name (If not institution	n, give street and number	er)		4b. City,	Town, or	Location o	f Death			y of Death		
			M	aryland General	l Hospital					Baltim	nore		N/A		
	Funeral		5. Social Security Number	6. Sex 7. 1 → M 2 □ F	Age (In yrs. last		If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birti (Month, Day	h v, Yea <i>r)</i>	9. Birthpla	ace (State or Forei	gn
	Director		212-72-8425		49	Yrs.					Jan 31	, 1957	So.	Carolina	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	ocation						10	d. Inside City Limit	ts
	Mary 4 sho	Ď	Maryland	N/A				Ba	altimore					1 X Yes 2 □ N	10
	1 28a	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Count	ry?	
	73a o 23a o	O E	87 Ashlar Hill Court						2123	39			U.S.A		
	ifier death with the Marylar r Items 23a or 28a-f show	Funeral	11. Marital Status	12. Was Decede Armed Force	int Ever in U.S.	13.	Was Deced	lent of Hi	spanic Orig	gin? (Spe , Puerto f	cify Yes or No- Rican, etc.)		ce - America		
98	hours after death with the Maryland tural, or Items 23a or 28a-f show al Ever dividing be notified at	y Fu	1 Never Married 2 Mar	ried 1 🗆 Yes 2   If Yes, Give	<b>X</b> <sup>No</sup>		1 ☐ Yes		Specify:			Speci	4	lack	
21215-0036	ural'.	d by	3 Widowed 4 Divorced	Year or Date		Sa Dago	dent's Usua	I Oggung	ntion		1	16b, Kind of E			
15-	"nat	lete	(Specify only highe	st grade completed)		(Give	kind of wor DO NOT us	rk done d se retired,	luring most	of workir	ng				
212	within iene.	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)				ce Tech		i	Baltin	nore City	Light Rail	
þ	be filed within 72 hours a ital Hygiene. id other than "natural", o event, the Medical Ever	BeC	17. Father's Name (First, Middle,	Last)		-			18. Mothe	r's Name	(First, Middle,	Maiden Suma	me)		
/lar	should be ind Mental a marked o umetic eve	ToE	Edw	ard Lawhorn							Ma	rie Lawho	rn		
Maryland	and and le m		19a. Informant's Name/Relations	hip (Type, Print)	1		•				ral Route Number, City or Town, State, Zip Code)				
	1 and 2 Health em 27 ther tr		Frances Lawhorn V	Vife	20h Plana		7 Ashlar psition (Nan		ourt Ba		e, Maryland	20c. Location	City or Toy	.m. Ctata	
	00-		20a. Method of Disposition 1 □ Burial 2 □ Cremation	3 □Removal from Sta	l come	itery, crei	matory or o	ther place	9)						
ţim			'4 □ Donation 5 □ Other (S	0 0		Charles and the same	on Park			-	06/01/06	E	Baltimore,	Ma.	
Bal	permit. Departr Imports any inj		21. Signature of Fulleral Service	11 50	5	P	Es	step B	rothers	Funer	al Service,	P. A.			
			23a. Part1. Enter the disease, o	r complications that cau	sed the death. D	o not ent	13	300 Eu	itaw Pla	ice Ba	ltimore, Mo	<del>: 21217</del> —		Approximate Interval Between	
	Pnysician /Medical Examiner	ı	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a		ce of):								Onset and Death	
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<b>S</b> c	as a consequence										
P.O. Box 68	that the death certifica ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2 Fetal dea	ath 3[	□Ectopic pr □ Other (sp						ate of deliver	y Day Year	
rds, P	w requires that been signed b should be det	by	Part II. Dther significant conditions to the page of t	ons contributing to deal	h but not resulting	g in the u	inderlying c	ause give	en in Part I.		23e. Did to	\_/		a cause of death?	٧n
Il Records,	ding Physicien: The law requ n. After this certificate has been funeral director, page 2 shoult	Completed											prior to com death?	sy findings availab pletion of cause o	ole f
Vital	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:				Othe	200		(Check only o		. :-		
of	Phys	To.	1  Yes 2 No 27. Manner of Death	28a. Date of	Injury 28	Outpatier  b. Time o		A	4 🗆 Nu	-	ne 5 Resid 28d. Describe h				_
on	ding h. h. After funer	tlon	Natural 5 ☐ Pendi	/A fon th	Day Year)	Injury	М	8c. Injury Work 1 □ °	(? Yes 2 🔲 I			,,			
Division	al or Attending after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could 4 Homicide deterr	not be 28e, Place of	Injury - At home , etc. (Specify)	, farm, st	reet, factory	, office		2	28f. Location (S City or Tov		ber or Rural	Route Number,	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C		ng Physician: To the be Examiner: On the bas and manne	is of examination										
)	Total within Comp	×	29b. Signature and title of certific	"berai	MD		290	. License	number	4:	8	29d. Date sign 5 ) 2 8		Oay, Year)	
	٧)		30. Name and address of person	EROL	4410	7	Print)	LS	Ro	)	BAL	10 0	nDa	1211	
**. ?e	Sta Regist	ate rar	31. Date filed (Month, Day, Year JUN	0 7 2006 D	istrar's Signature	B	Coore								

	Physicia /Medic Examin Funeral Director		For State Registrar	State of Maryland / Department of Health and Mental Hygiene 2006 17928  Certificate of Death Reg. No.											3	
*			1. Decedent's Name (First, Middle, Li	LEWI	LEWIS					1	2. Date of Death Month Day A  A  B  B  C  B  C  C  C  C  C  C  C  C  C			3. Time of Death 4:30P. M	ı	
		er	4a. Facility Name (If not institution, gi BALTIMULE PEHABIL  5. Social Security Number  6.	NDED (	n yrs. last birthday) If Under 1 Year If Under 24 Hrs				4 Hrs. 8	DE Date of Birth	4c. County of Death N/A  9. Birthplace (State or Foreign			n		
Ą			218-80-3116 Usual Residence of Decedent	1□M 2/0 F 46 Yrs.			Months Days Hours Min.			Min.	8. Date of Birth (Month, Day, Year) Mar 26, 1960			Maryland		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other then "natural", or Itema 23a or 28a-f ehow any injury or other traumatic event, if a Modical Examinational Control of the December 1 and Once.	tor	10a. State 10b. County	10c. City, Town or Location				Baltimore				10d. inside City Limits 1 ☐ Yes 2 ☐ No				
		Direc	10e. Street and Number 4637 Park Heights Ave		10f. Zip Code 21215					1	0g. Citizen o	f What Cou				
		by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 X Yes 2 If Yes, Give	1 X Yes 2 □ No			Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2 ★ No Specify:				No- 14. Race - American Indian, Black, White, etc.  Specify: Black				
		Completed	15. Decedent's Elementary/Secondary (0-12)	ade completed)	completed) (Give kii			ent's Usual Occupation kind of work done during most of working O NOT use retired) Secretary				16b. Kind of Business/Industry  Recovery Program				
		To Be C	17. Father's Name (First, Middle, Las Lero		18. Mother's Nar					me (First, Middle, Maiden Surname)  Margaret A. Norris						
			19a. Informant's Name/Relationship Daryl Harcum Husban			19b. Mailii <b>1</b> 7	ng Addres 725 No	s (Street a	nd Number son Stre	r or Rural I eet Balt	Route Number imore, Ma	City or Tow ryland 21	n, State, Zi 1 <b>217</b>	ip Code)		
			20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Special Control of Control		20b. Place of Disposition (Name of cemetery, crematory or other place King Memorial Pa							n - City or Town, State indsor Mill, Md.				
Balt			21. Sign of Funeral Service Lice	JUal	lee	P 25	2. Name a E 1	nd Address step Br 300 Eut	of Facility others I taw Pla	uneral ce Balti	Service, I more, Md	P. A. 21217				
Division of Vital Records, P.O. Box 68760, 🤟	The law requires that the death certificate be executed XX in the has been signed by the attending physician and a signed be detached for use as the burial-transit and be detached for use as the burial-transit and a signed by the signed by	dicai Examiner	23 Part 1. Enter the disease, or complications that ceused the death. No not enter the mode of dying, such as cardiac or respiratory arrest, shock, or inferit failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):												#	
		Physician/Medical	F FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)										23d. Date of delivery Month Day Year			
	uires that signed bi id be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I								23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown					
	To the Hoapital or Attending Physician: The law require within 24 hours after death.  To the Funeral Director: After this certificate has been stoompletely filled in by the funeral director, page 2 should	Completed								autopsy performed?			prior to co death?	Vere autopsy findings available brior to completion of cause of leath? ☐ Yes 2 ☐ No		
		o Be	25. Was case referred to medical examiner?  1 ☐ Yes = 2 ☑ No	Hospital: 1 ☐ Innat	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)											
		ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigati	28a. Date of In (Month, D	28a. Date of Injury (Month, Day Year)  28b. Time of Injury  28c. Injury at Work?  1  Yes 2  No						28d. Describe how injury occurred					
Divis		Certification:	3 Suicide 6 Could not 4 Homicide determine	286. Place of II	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28	281. Location (Street and Number or Rural Route Number, City or Town, State)					
		edical (														
)		Me	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  MAY 30, 2006									2006				
_	<i>y</i>		AURORA C. TA	N 3907	death (Item ) LDC strar's Signatu	H RA	Print) VEN	BOU	LED	ARD	BALT	MORE	E, M	21218		
	St: Regist	ate rar	31. Date filed (Month, Day, Year)	2006 32. Hagis	ALLE A	de d	bossti	,								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 12:55AM Ruth Florence Leyh June 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner ROSC oder 1 Year vare Hospital Center Himore Manhlin s 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 F Days Min. Hours 220 05 1131 Yrs. 87 Baltimore, Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or itema 23a or 21128 USA 4825 Forge Acre Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. within 72 hours after 1 □ Yes 2 ŽNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: Specify: White 3 Vidowed 4 □ Divorced "naturaj". Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) than Elementary/Secondary (0-12) Baltimore Gas & Electric Co Sales Person 12 other t permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked othe any injury or other traumatic event, 9068. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Ruhe Florence Katenkamp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4825 Forge Acre Drive Baltimore, Maryland 21128 Lenora R Gentry Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBuriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cardens of Faith Cem. June 6 2006 Baltimore,Maryland re of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home Inc Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a Part 1 Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory
Due to (br as a consequence) **Physician** /Medical Examiner Morom Leukemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sicien and a burial-transit or Attending Physician: The jaw requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical phys IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 3 Probably 4 Unknown No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performe certificete 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient Certification: To 2 ER/Outpatient 3□ DOA 27. Manner of Death
1 Natural
2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation To the Hospital or Attend within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certify 29c. License number 222463 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franklin Square Drive, Baltimore, mo, 21837 9000 HITHOU 32. Registrar's Signature State 2844 Registrar

ext, Ruth

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FRANK JOSEPH LAMM 2006 JUNE 1:45P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4403 White Avenue Baltimore City Baltimore City 8. Date of Birth (Month, Day, Year) AUG. 29, 1925 If Under 1 Year If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 220~24~4024 1 M 2 □ F 80 Yrs. Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County #ohe 10d. Inside City Limits ir then "natural", or items 23a or 28a-f eho Tre Medical Examiner must be mutified at Maryland Baltimore City 1 XYes 2 No Directo Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4403 White Avenue 21206 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after NGYes 2 No If Yes, Give WW 11 Year or Dates: WW 11 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: δ Specify: 3XXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) 12 yrs. College (1-4or 5+) 4 yrs. Graphic Artist Black & Decker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill thent of Health and Mental H tant: If Item 27 is marked of Frank Joseph Lamb Frances Mary Airey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4403 White Avenue Baltimore, Md. 21206 Patricia M. Laro (Daughter) 20a. Method of Disposition

X

Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of H Important: If Ite ony injury or ot once. Moreland Memorial Pk, 6-9-2006 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sprature of Funeral Service Licensee Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that exised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CANCER nonth /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) certificate be executed burial-transit and Due to (or as a consequence of) physician s the burial Box 68760, Physiclan/Medical use as attending to for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 4☐ Pregnant at time of death signed by the a 5 Other (specify) o. 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ should ! 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed of Vital 1 ☐ Yes 2 ☐ No 1 Yes 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funerel Director: After thi
cumpletely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending Division 1 Natural 5 Pending Injury investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the date of a date of a state of the date 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month Day Year) no address of person who completed cause of death (Item 23a) (Type, Print) V. Charles ST Bonc 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year WILLIAM B. LOVELACE JUNE 2006 5:10 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 4034 LYNDALE AVE. BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Hours 1 XM 2 ☐ F Director UNK 66 03/08/1940 VA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "naturel", or Iteme 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Directo 1 XYes 2 □ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4034 LYNDALE AVE. death 21213 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "naturel", or Itel 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10TH OFFICER TRUCKING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WIGGIE LOVELACE MATTIE WALLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM A. LOVELACE 2 FIRST LIGHT CT., ROSEDALE, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If eny Injury or once. BAYVIEW CREMATORY06/08/2006 BALTIMORE, MD 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Fineral Service License 2007-09 EASTERN AVE., BALTIMORE, MD 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) ROSTATE **Physician** CARCINOMA FIVE YEARS /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760 ician/Medicai attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached Physi Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably 1 🗌 Yes 2 No 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed Division of Vital 1 Yes 2 1 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident investigation 1 Tes 2 No Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide fo the within 24 hours the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Exami the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marrier as stated.

In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marrier as stated. 29b. Signature and title of certifier 29c. License number DOO 51946 30. Name and address of person who completed cause of death (Ren. 23a) (Type, Print) JOHNS HOPKINS HOSPITAL 401 N. BROTOWAY ST BALTIMORE 21231 MD PILI ROBEKTO 2. Registrar's Signature 31. Date filed (Month, Day, Year) JUN 0 7 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend, item 31 per 1856 6-7-06 yt.
State of Maryland / Department of Health and Mental Hygiene

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2006 Month **Physician** LANDSMAN FRANCES /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore may Hospital of Baltimase n ty 8. Date of Birth 10/07/1924 Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country)
 D A **Funeral** 1□M 2₩F PA 81 219-14-8569 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f shov the Medical Examiner must be notified a BALTIMORE BALTIMORE 1 ☐ Yes 2 No Directo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 TANNER COURT 21208 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Spacify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental HIRSCH **GERTRUDE** LASCH OSCAR 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MELVIN LANDSMAN / HUSBAND 5 TANNER COURT - BALTIMORE, MD 21208 Item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite eny injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON CHIZUK AMUNO 6/6/2006 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 1000 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** morrhagic لم /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 22 No 24a. Was an autopsy performed? Yes 25 No 1 ☐ Yes 25. Was case referred to medical examiner?

1 See 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2 ER/Outpatient 3 DOA After thi 27. Manyer of Death 28b. Time of Injury Certification; 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No neral Director: A filled in by the fo 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai ş 29b. Signature and title of certifier 29d. Date signed (Month, Dev. Year) ankarani 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LANKARANI MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 7 2006 Registrar

krown

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		1- For State of Maryland / Dep Registrar Ce	artment of Health and I		21116 1/93
		Decedent's Name (First, Middle, Last)	Timodio or Bodin	Reg. N	3. Time of Death
iysici Medic		LORRAINE	LILIENFELD	Nonth D Vune 5	2006 11:41 am
kamir		4a. Facility Name (It not institution, give street and number)  Sinai Hospital of Baltimore	4b. City, Town, or Location of Deat Baltimore C	ity 4	c. County of Death N/A
eral		5. Social Security Number  213-34-3779  G. Sex  1 M 2 F 83  Yrs.  Usual Residence of Decedent	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.		9. Birthplace (State or Foreign Country) MD
fielat	tor	10a. State   10b. County   10c. City, Town or L.			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
at be not	ai Director	10e. Street and Number 3203 OLD POST DRIVE #7	10f. Zip Code 21208	10g. C	Citizen of What Country?
any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
he Medical	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation skind of work done during most of wor DO NOT use retired) SEWIFE	king 16b.	Kind of Business/Industry  OWN HOME
tic event,	To Be C	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maide	
er trauma			ng Address (Street and Number or Ru D GIST AVENUE - BA		·
ury or oth		20a. Method of Disposition  1 Disposition  20b. Place of Disposition  3 Removal from State  4 Donation 5 Other (Specify)	materia andharatara)		SEDALE, MD
any inju		21. Signature of Funecal Service Licensee 2	2. Name and Address of Facility S(		& BROS., INC. ESVILLE, MD 21208
cian lical		23a. Part1. Iter that 1 lease, or complications that caused the death. Do not en shoot or heart illure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a	ter the mode of dying, such as cardiad	or respiratory arrest,	Approximate Interval Between Onset and Death Week
the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last  b.	failure		lweek
completely filled in by the funeral director, page 2 should be detached for use as	by Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
uld be deta	d by Pr	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		use contribute to the cause of death?
, page 2 sho	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
rector	Be	25. Was case referred to medical examiner?  Hospital:	Other	th (Check only one)	
ral d	. T	1  Yes 2		ome 5 Residence 28d. Describe how inju	
y the fune	Certification:	1 🖸 Astural 5 Dending (Month, Day Year) Injury 2 Accident investigation 3 Suicide 6 Could not be	Work? M 1 ☐ Yes 2 ☐ No		nd Number or Rural Route Number.
filled in b		building, etc. (Specify)  29a. Certifier  1 Dertifying Physician: To the best of my knowledge, deat	h occurred at the time, date and place	City or Town, Stat	s) and manner as stated
oletely	edicai	(Check only 2 Medical Examiner: On the basis of examination and/or in one)	vestigation, in my opinion, death occu	rred at the time, date an	id place, and due to the cause(s)
comp	₹.	29b. Signature and little of centifier  M.D.	29c. License number RES-000		ate signed (Month, Day, Year)  NE 5 2006
		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	Baltim	ne 5, 2006
Sta gistr	ar	31. Date filed (Month, Day, Year)  32. Repistrar's Signature	hole		
Rev 1/20	U I				

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		•	For State Registrar	State of Mar	-	partment of Healt ertificate of Dea		Reg. N	711116	17934
	Physici		1. Decedent's Name (First, Middle, L.	asi)			Α.	Date of Death Month D	ay Year	3. Time of Death  O 2 10 A M
0	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or Locat	tion of Death		c. County of Deat	
	Funeral			Sex 7. Age (	'In yrs. last birtho		nder 24 Hrs. 8. 8	Date of Birth Month, Day, Yea	9. Bird	hplace (State or Foreign
	Director		218-28-1514 Usual Residence of Decedent	1□M 200F 7	5 Yrs	Months Days Hou		ev 28,1	930	Md
ē	ryland		10a. State 10b. County	. / .	IOc. City, Town o					10d. fnside City Limits 1 Yes 2 □ No
Molli	death with the Maryland me 23a or 28a-f ehow rn. ust be notified at	Funeral Director	10e. Street and Number	1/4	Balti	10f. Zip Code		10g. (	Citizen of What Co	
E	th with 23e or	al Di	A COLUMN TO THE REAL PROPERTY OF THE PERTY O	er Ave		212	17		USA	
0	itame	uner	11. Maritaf Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces?	er in U.S.	<ol> <li>Was Decedent of Hispani If Yes, specify Cuban, Me</li> </ol>	ic Origin? (Specify exican, Puerto Rica	Yes or No- in, etc.)	14. Race - Ame Black, White	
9	72 hours after natural, or its	by	3 Widowed 4 Divorced	1 Tes No If Yes, Give Year or Dates:		1 ☐ Yes 2 No Spe	ecify:		Specify:	lack
7	in 72 h	Completed	15. Decedent's fine (Specify only highest g	rade completed)	(C	acedent's Usual Occupation live kind of work done during a. DO NOT use retired)	most of working		Kind of Business/	·
Ma	od with giene.	Com	Elementary/Secondary (0-12)	College (1-4or 5+)		ouse Keepi			College	
1:	d be fill ontal Hy sed oth	To Be	17. Father's Name (First, Middle, Las	50~			Mothel's Name (Fil Lula	,		
as: Maniego,	Fe, INIGE VIGITION ZINIONOSOO 5.1 and 2 should be filled within 72 hours after death with the Maryla Fheelih and Mental Hygiene. Item 27 is marked other than "natural", or itame 23e or 28e-1 ehou then traumatic event, the Modical Expruirer is used be notified as	F	19a. Informant's Name/Relationship		1 3 . *	ailing Address (Street and N	umber or Rural Ro	oute Number, City	y or Town, State, 2	
-	to I and I a		Castella B 20a. Method of Disposition	rown Dang		sposition (Name of crematory or other place)	AVE B	altimore	Location - City or	ZII
Known	Pages Pages nent of int: if It iry or o		Burial 2 Cremation 3 4 Donation 5 Other (Spec		Mt Z	in Cemetery	6-6-01	lo la	nsdowne	Md.
7	Dalitimofe, permit. Pages 1 a Department of Her Importent: if Item any injury or othe		21. Signature of Funeral Service Lice	ensee		22. Name and Address of F	Facility Chat	man-H	arris Fu	neral Home
9	4 442 4 4		23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications that caused the	he death. Do not	5340 Rei Sives enter the mode of dying, suc			Himore	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)		ESTIVE	HEART F	MILUR	E-		Onset and Death
	/Medical Examiner				consequence of)	MELLITUS				
	Pe #5	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of)	CTIVE PULMO	· · · · · · · · · · · · · · · · · · ·	SUEM	=	
٧	oo executed se executed cien and nurial-transit	Examiner	that initiated events resulting in death) Last		consequence of)		=	2186.42	_	
	8/00 sate be e	1	•	d. HTPE	RTEN	200				
	OX O	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1□Live birth 2	f pregnancy	2 Estania pragnancy			23d. Date of del	ivery
	F.C. BOX D&/ OF 10 to the death certificate b d by the attending physic letached for use as the b	by Physician/Medical	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4☐ Pregnant at ti 9☐ Unknown		3 Ectopic pregnancy 5 Other (specify)			Month	Day Year
		d by Pr	Part II. Other significant conditions	contributing to death but	not resulting in the	ne underlying cause given in f	Part I.			the causa of death?
	aw request seen 2 shoul	Completed						24a. Was an autopsy	24b. Were au	utopsy findings available completion of cause of
	al He							performed? 1 ☐ Yes 2 ☐ 1	? death?	
	ysician ysician is certif directo	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	t 2 ER/Outp	Other	Pface of Death  C.  Nursing Home		6 ☐Other (Spe	cify)
	ing Ph After th	L:uo	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Tin	ne of 28c. Injury at	28d.	. Describe how in		
	DIVISION OF VITAL HECOFIAS, I or Attending Physician: The law requires to effer death. Director: Affer this certificate hes been signe st in by the funeral director, page 2 should be	rtificat	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 29a Blace of laius	y - At home, farm (Specify)	, street, factory, office		Location (Street City or Town, Str		ural Route Number,
	lospital of hours of unersity filled is	Medical Certification:				death occurred at the time, da				
	o the hithin 24 o the Formplete	Med	one)  29b. Signature and title of certifier	and manner state		29c. License num	nber		Date signed (Mont	
	F S F Ö			PRIMAR	7 CARE	Daol	6948		06 05 06	•
	_3		30. Name and address of person who	o completed cause of dea	350 ARI	me Driet)		me no	223	+
	St Regist	ate rar	31. Date filed (Month, Day, Year)	2006 32. Resistrar	's Signature	Sparke				

The law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, signed by the at d be detached fo s certificate hes t lirector, page 2 s Hospital or Attending Physician: the funeral director, this After death. hours after death unerel Director: filled in by 24 hours To the I within 2 To the

**Funeral** 

Director

ne 23a or 28a-f shov

or iteme

e filed within 72 hours after de al Hygiene. other then "neturel", or Items vent, the Madical Examiner o

. Pages 1 and 2 should be filed w tment of Health and Mental Hygie tent: If Item 27 is marked other it jury or other traumatic event, ID

Important: if item. any injury or othe

Physician

/Medical Examiner

permit. Page Depertment

Baltimore, Maryland 21215-0036

with the Maryland

10+1 State Registrar

2003 Medical Parkway Smite 100 Annopolis My 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

37 Registrar's Signature

			1 - For State Registrar	State of Marylar			t of Hea e of De			jiene eg. No.	2001	5 17936
	Physicia		1. Decedent's Name (First, Middle, Last) Emma Elizabeth	Mazurek					2. Date of Dea Month June	Day	Year 2006	3. Time of Death 7:45 A.M
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City,	Town, or Loc	ation of Death			County of Dea	
	- Autiliii	٠.	Manor Care-Wood	dbridge Valle	v		Catons	ville			Baltin	nore
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	V	If Under	1 Year If U	Jnder 24 Hrs.	8. Date of Birth (Month, Day	W=)	9. Bir	thplace (State or Foreign
	Director		199-07-7044	<sup>M 2</sup> ₩ F 87	Yrs.	Months	Days Ho	ours Min.	Sept 10	, 19		ennsylvania
	D		Usual Residence of Decedent									
	hours after death with the Maryland Lural', or Itams 23a or 28a-f show at Exactions trust be rediffed at		10a. State 10b. County	10c. Ci	ly, Town or Lo	cation						10d. Inside City Limits
	Ma-f s	to	Maryland Baltimore	e C	atonsv:	ille						1 ☐ Yes 2X No
	h the	Directo	10e. Street and Number			10f. Zip	Code		1	0g. Citiz	en of What C	ountry?
	1 wit		2410 Harbor Wood I	Road			21228			USA		
	deal	Funeral		22. Was Decedent Ever in U Armed Forces?		Vas Deced	lent of Hispan	nic Origin? (Sp	ecify Yes or No-		4. Race - Am	
٥	after or its	F	1 Never Married 2 Married	1 ☐ Yes 2 TheNo				exican, Puerto	nican, etc.)		Black, Whi	
3	ours a	by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		∏Yes 2	ZIXINO SP	ecity:			Specify:	White
2-0036	CI W	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deced	lent's Usua	I Occupation	a most of work	rina	16b. Kin	d of Business	/Industry
N	within 72 ene. than "na!	pid	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)	life. L	OO NOT us	e retired)	g most of work	9			
N	gien gien	5	12		Unit	t Cle	rk			Но	spital	
	be filed within 7; ital Hygiene. d other then "n avent, it e Medi	Be (	17. Father's Name (First, Middle, Last)				18.	Mother's Nam	e (First, Middle, I	Maiden S	Sumame)	
yland		10	George Wesner				M	abel L	udwig			
С.	s 1 and 2 should t f Health and Ment itam 27 is marked other traumatic a		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailin	g Address	(Street and f	lumber or Rur	al Route Number	. City or	Town, State,	Zip Code)
Ma	P = K T		Lynn Sokalski Da	aughter	2410	Harb	or Woo	d Road	Catons	v111	e. MD	21228
ē	of Head		20a. Method of Disposition	20b. F	Place of Dispo-	sition (Nam	ne of	1	Date	20c. Loc	ation - City or	Town, State
more,	Pages ment of tant: If it lury or o		1 🖾 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	. Jose	-		6/7/2	2006	homs	River	, New Jersey
Salt	permit. Page Depertment Important: If any Injury of once.		21. Signature of Fund al Service License							htor	Schwa	b Witzke
ă	permit. Depertuimports any inju		) (Mha(	Koll	1	unera	al Home	e of Ca	atonsvil	le,	Inc	b Witzke Maryland 21
			23a. Part1. Enter the disease, or comptie	cations that caused the deal	h. Do notente	er the mode	e of dving, su	ch as cardiac	or respiratory arri	LUIIS est	viiie,	Approximate
			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	/ .							Interval Netween Inset and Death
	Physician /Medical		disease or condition resulting in death)		a	ma	nujo	puth	5			Gillung
	Examiner			Due to (or as a consec	juence of):		- 1	,	1			
	3		Sequentially list conditions if any, leading to immediate									
_	sit ad	line	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	juence or):							
	ecut and tran	Examine	that initiated events resulting in death) Last									
Š	e ex	<u>ω</u>	rossining in country East	Due to (or as a conseq	luence or):							
8/60,	licate be executed physicien and s the burial-transit	dicai	d									
0	ing p	0	IF FEMALE:									
ž 2	death certifi e attending id for use as	clan/M	23b. Was decedent pregnant 23	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pre	egnancy			23	d. Date of de	
	ed fo	SC	in the past 12 months?	4☐Pregnant at time of of 9☐ Unknown	leath 5	Other (spe	ecrfy)				Month	Day Year
5	by the	Physi	9 Unknown									
as,	The law requires that the death certificate hes been signed by the attending page 2 should be detached for use as	by	Part II. Other significant conditions con	And I	ulting in the ur	derlying ca	ause given in	Part I.	23e. Did tob	acco us	e contribute to	o the cause of death?
2	an si	ed		umelos	Minu	as			1 □ Y€	s 2/2	No 3□P	robably 4 Unknown
ecor	s be	plet	C						24a. Was a		24b. Were a	utopsy findings available completion of cause of
Ĕ	The lav	Completed							autops	ned2	death?	
V Ka		O	25. Was case referred to medical				26	Place of Deat	1 ☐ Yes 2 h (Check only on	No No	1 LJ Yes	2 □ No
	ding Physician: h. After this certific funeral director,	0	examiner?	ospital:	ER/Outpatien	3 DO	04		ome 5 Reside		Other (0)	. 4.1
5	Phy	-	27. Manner of Death	28a. Date of Injury	28b. Time of		Bc. Injury at Work?	and sing ric	28d. Describe ho			киу)
5	ding F h. After funera	텵	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	м	Work? 1 ☐ Yes	2 □ No				
VISION	l or Attending after death. Diractor: After I in by the funer	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, stre	et factory			28f. Location (St.	reet and	Number or R	ural Route Number,
5	after Dira	ert	4 Homicide determined	building, etc. (Specif	<b>y</b> )		, 011100		City or Town			oral riodio riompor,
_	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	Ö	29a. Certifier 1 Cartifying Phys	ician: To the best of my kno	wledge death	occurred s	at the time of	ate and place	and due to the		ad macaas	a state of
	Fun Fun stely	edicai	(Check only 2 Medical Examin	er: On the basis of examina and manner stated.	tion and/or inv	estigation,	in my opinior	n, death occur	red at the time, da	ate and p	olace, and due	s stated. It to the cause(s)
	ithin than	Med	29b. Signature and title of cedifier	S. S. Marinor States.		29c	. License nun	nber 🚜 -	2	9d. Date	signed (Mont	h, Day, Year)
	F ₹ F 8			and			DZ	1769		1-	1011	6
1	5 7			neto .			, -			0/	1/	
	7		30. Name and address of person who con	11-11/2		Print)	820	CO	Pero T	200 2		1 21208
			31. Date filed (Month, Day, Year)	32. Registrar's Signa	194		278		-ne 1	7	7	-1-3
	Sta	IG.		Jan Jan Golgine		AP.						

			1 - For State Registrar	State of Marylar		artment of I			giene	06	17937
4	Physici	200	1. Decedent's Name (First, Middle,	Last)				2. Date of De	ath Day	Year	3. Time of Death
	Physici /Medi		Leroy	Richard	Ma	son		May			3:18 <sup>Рм</sup>
	Examir	ner	4a. Facility Name (If not institution,	give street and number)		4b. City, Town,	or Location of Deati	1	4c. County	of Death	
4			Prince George			Cheve				e Geor	rges
	Funeral		,	3. Sex 7. Age (In yrs. 12℃ M 2 ☐ F	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	(Month, Da	th <i>y, Year)</i>	Country)	e (State or Foreign
À	Director		214-58-2459 Usual Residence of Decedent	53	115.			July 2	0,1952	Mary	land
	land w		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation		·		10d.	Inside City Limits
	Mary 	ρ'n	MarylandDringo	Coorgos Tan	dover						1 Yes 2 No
	1 the	rec	MarylandPrince 10e. Street and Number	Georges Lan	uover	10f. Zip Code			10g. Citizen of	What Country'	?
	death with the Maryland me 23a or 28e-f ahow rinust be notified at	0	1208 Hill Roa	ā		20785			USA	,	
	deatl	Funeral	11. Marital Status	12. Was Decedent Ever in U	.S. 13.		) Hispanic Origin? (S Jan, Mexican, Puert	pecify Yes or No		e - American I	Indian,
9	after or its	F	1 ☐ Never Married 2 ☐ Marrie	Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give				o Hican, etc.)		ck, White, etc.	
93	rai',	d by	3 Widowed 4 Divorced	Year or Dates:		1 ☐ Yes 2√∑ No	Specify:		Specify	Black	<
5-(	within 72 hours after ene. than "natural", or ite	Completed	15. Decedent's (Specify only highest	Education grade completed)	(Give	dent's Usual Occu	during most of wor	king	16b. Kind of B	usiness/Indust	try
2	vithin ne. hen	ig I	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	nd)		_		
2	lled v lygie her t		17. Father's Name (First, Middle, Li		Ware	housema					n Paper
anc	be filed ntal Hygi ed other event,	Be		45()			18. Mother's Nan	10 (First, Middle,	Maiden Suman	,	
Z Z	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, Ita Mi	<sup>2</sup>	Jereminah  19a, Informant's Name/Relationshi	Mas			Mary	F.		Hebb	Tilber-
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylar at of Heelih and Mental Hygiene. If Item 27 is marked other than "natural", or iteme 23a or 28e-f ahow or other traumatic event. If a Medical Examinar must be netitied.						and Number or Ru				
	1 an Heelt em 2 ther		Paula Mason /		1208	HIII I	d Lando	ver, M	arylano 20c. Location -		
ية	ages nt of :: If it		1 Burial 2 ☐ Cremation 3	Duellional Holli State		osition (Name of matory or other pla					
Baltimore,	rtmer rtant njury		4 ☐ Donation 5 ☐ Other (Special Service ☐	· Inni		te Hear		2/2006	Lexin	gton F	Park
Ba	permit. Pages 1 and 2 of Department of Heelth ar important: If Item 27 is any injury or other traughte.		21. Signature di Pinsial Sevice L	2		2. Name and Addre	Ad	ams Fu	neral I	Home F	PA
100			23a. Pari 1. Enter ne disease, o o	191			uasco R			-	
			shock, or art failure. Lis or	nly on cause on each line.	n. Do not ent	er the mode or dyl	ng, such as cardiad	or respiratory a	rest,	Ap Intr	proximate erval Between iset and Death
	Physician /Medical	0. "	disease or condition resulting in death)	_a. //140C	ARCH	pf IN	tirch	on			
	Examiner			Due to logas a conseq	uence of):	11					
6.		P.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq	uence of	1+1+c	Erry D	15 CASE			
172	be executed sicten and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				/				
W.	exec in an	Exa	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):						
8760	ate be executed thysicien and the burial-transit	dical		d							
9	ifficate g phys as the	edi									
Вох	To the Hospitel or Attending Physicien: The law requires that the death certifics within 24 hours alter death. For the Funerel Director: After this certificate has been signed by the attending pt completely filled in by the funeral director, page 2 should be detached for use as it	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		7E			23d. Dat	te of delivery	
	deati e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of d		Ectopic pregnanc Other (specify) _	У		Мо	nth Day	Year
P.0	that the dead by the detached	hys	9 Unknown	9□ Unknown							
	es tha igned be det	ру Р	Part II. Other significant condition	s contributing to death but not resi	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use cont	ribute to the ca	ause of death?
Ď	w require been sig should b	ed						1₩	'es 2□No	3 Probably	4 □Unknown
Vital Records,	awre	Completed						24a. Was	an 24b. \	Vere autopsy	findings available
Ä	ysicien: The lav is certificete has director, page 2 i	E							rmed?	prior to comple death? I 🗌 Yes 2 🗎	tion of cause of
ta	ician: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes		L 105 2L	1 140
>	Physical this ce	To B	examiner? 1 ☐ Yes 2√∑ No	Hospital: 1 ☐ Inpatient 2X	ER/Outpatien	t 3 DOA Ott		ome 5 Resid		er (Specify)	
٥	ding Ph. After the funeral	1	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Inju			ow injury occurr		
<u>.</u>	ttendir death. tor: Af the fu	atic	1  Natural 5  Pending 2  Accident investiga	tion	,,		Yes 2□No				
Division of	i or Attendi after death. Director: A in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be ed 28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (S City or Tow	Street and Numb	er or Rural Ro	ute Number,
0	rs aft								., 5.0.0,		
	To the Hospitel or Attending the Within 24 hours after de To the Funerel Directo completely filled in by the	edical	29a. Certifier 1 Certifying (Check only 21 Medical Ex	Physician: To the best of my kno caminer: On the basis of examina	wiedge, death	occurred at the til	me, date and place,	and due to the	ause(s) and ma	nner as stated	f.
	the him 24	led	Une)	and manner stated.							
	Y vitt	Σ	29b. Signature and file of certifier			29c. Licens	e number		29d. Date signed	I (Month, Day,	Year)
	5		1/6	1/1/	MY	03.	1527		6/2	106	
	7		30. Name and address of person when						1		
	die la de la company		David Jacobs 3	3001 Hospital 2. Registrar's Sign	Drive	Chever	rly, Mar	yland	20785		
	Sta Registr	te ar	31. Date filed (Month, Day, Year)	106 Jestin Silver	The state of the s						
A. 160		- F	VVII								

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F ertificate of a			iene 2 ( <sub>eg. No.</sub>	06	1793
	Physici		Decedent's Name (First, Middle, William Clements Mus					2. Date of Death	Day	Year	3. Time of Death
(Ne	/Medio		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, o	r Location of Death	June 2 20	4c. County		7:55 P <sup>M</sup>
			12805 Fastern Avenue 5. Social Security Number 6		e (In yrs. last birthday	Baltimore  If Under 1 Year		T	Balti		
	Funeral Director		214 16 9200	1√ M 2□ F 86		Months Days	Hours Min.	8. Date of Birth (Month, Day, December	5 1919	9. Birthpla Countr Baltim	ore, Mary Land
To co	wor.		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation					d. Inside City Limits
Mar	8a-1-el	Director	Maryland Baltimore	2	Baltimore (						1 ☐ Yes 2 ☐ No
And the transfer of the transf	3a or 2 at be ru	al Dire	10e. Street and Number 12805 Fastern Avenue			10f. Zip Code 21220		10	og. Citizen of W USA	/hat Countr	y?
6		y Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 XX es 2 1		Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S) nn, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		- Americar c, White, et	
-00036	stural cal Ex	ed by	2√XWidowed 4 □ Divorced  15. Decedent's	Year or Dates:	W II	dent's Usual Occup			16b. Kind of Bus	Whi	ite
-C1213	then "ng	Completed	(Specify only highest of Elementary/Secondary (0-12)	rade completed)  College (1-4or 5	(Give	kind of work done of DO NOT use retired	during most of word ()	king			
	ntal Hygi of other event.	Be C	17. Father's Name (First, Middle, La		Tuvea		18. Mother's Nam	ne (First, Middle, M			Shipyard
2		2	John A Mueller  19a. Informant's Name/Relationship	(Time Print)	105 14-77		Anna Wag				
, <b>Ra</b>	27 is	1 3	A. Irene Summers	(Type, Fluid)		ng Address (Street a hilworth Av		timore, Mar			ode)
more,	3.2 = 5		20a. Method of Disposition 1 ∰Burial 2 ☐ Cremation 3	☐Removal from State		osition (Name of matory or other plac			20c. Location - (		n, State
	artmen ortant: injury		4 ☐ Donation 5 ☐ Other (Special Service) Lice	city)		mmial Gam		2006 LE	el Air, l	Marylar	rlfr
מ מ	Departr Import eny inj	1	Mailes	maha / A	1	Lassaho Fin	eral Home	Inc	1 1240	26	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	mplications that caused by one cause on each like	the death. Do not en	ter the mode of dying	g, such as cardiac	or respiratory arra	and 212	JO A	approximate nterval Between Onset and Death
9	hysician /Medical		disease or condition resulting in death)		5	neeks					
Ε	xaminer	_	Sequentially list conditions,	b	a consequence of):	Can	a sta			5	meet
Cuted	nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c Due to (or as	a consequence of						
Do exe	physicien and s the burial-transit		resulting in death) Last	Due to (or as	a consequence of):						
tificate l	g phys as the	ledical		d							
The law requires that the death certificate be executed	been signed by the ettending should be detached for use a	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	ol delivery th Da	ay Year
S, T	gned b	by Pi	Part II. Other significant conditions	contributing to death bu	ut not resulting in the u	nderlying cause give	on in Part I.	23e. Did toba	acco use contrit	oute to the	cause of death?
	been s	eted	- An	nic Ob-	truchu	e Peilm	may	1 ☐ Yes		Probabl	ly 4 □Unknown
The lay	ite hes age 2	Completed	- Org	bestur	1			24a. Was an autopsy performe	ed? de	ath?	findings available letion of cause of
	ector, p	Be C	25. Was case referred to medical examiner?	200 100				1 ☐ Yes 26th Check only one		Yes 2	
2 4	ar this o	٠ <u>.</u>	1 Yes 2 No	Hospital: 1 ☐ Inpatie	y 28b. Time of		4   Nursing Ho	ome Hesiden 28d. Describe how			
	or: Afte	atlor	tural 5 Pending 2 Accident investigati	(Month, Day on	Year) Injury	Work	? ′es 2 □ No	Est. Bosonio no la	e inquiry occurren		
Lei or Att	s after de al Direct ed in by t	Certification:	3 Suicide 6 Could not 4 Homicide determine		rry - At home, larm, str (Specify)	eet, lactory, office		28l. Location (Stre City or Town,	et and Number State)	or Rural R	oute Number,
To the Hospitel or Attending Physician:	within 24 hours after death.  To the Funeral Director: After this certificete hes completely filled in by the funeral director, page 2	Medical	29a. Certifier Certifying F	thysician: To the best of intiner. On the basis of and manner sta	examination and/or in	n occurred at the time vestigation, in my op	e, date and place, inion, death occur	and due to the cau red at the time, date	use(s) and mand e and place, an	ner as state id due to the	d. e cause(s)
70 t	To t	Σ	29b. Signature and title of certifier	0.0		29c. License	number	290	d. Date signed	(Month, Day	r, Year)
,	INTI	- 1	30. Name and address of person who	completed cause of de	eath (Item 23a) (Type,	Print)	3559	3	61	5/1	7006
	10,		m Fo	HN & 04	+ 112	+ Mace	Aue.	, Balt	more	MD	2/22/
	Sta Registra		31. Date filed (Month Day, Mear) 20	06 Hegistra	r's Signature	de	•		/		/

MUELLER

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

31. Date filed (Month, Day, Year,

IIIN 0

32 Registrar's Signature

			1 - For State of Maryland /	•	artment of Hertificate of L		nd Me		ne 0 0	6	17940
			Decedent's Name (First, Middle, Last)				1	2. Date of Death		·	3. Time of Death
	Physici /Medic		Margaret Josephine Magyar					June 2,	2006	/ear	12:01A <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		Death		4c. County of		
			5917 Linthicum Lane		Linthi		414				undel
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last b	Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day, Y	ear)	9. Birthp Coun	lace (State or Foreign try)  MD
			Usual Residence of Decedent					10/03/1	914		пр
	yland		10a. State 10b. County 10c. City, To	wn or Lo	cation					1	0d. Inside City Limits
	e Ma	ctor	MD Anne Arundel Pas	ade	na						1 ☐ Yes 2. No
	ith th	Funeral Director	10e. Street and Number		10f. Zip Code			10g	. Citizen of Wh	at Coun	itry?
	s 23e	ral	7662 Pine Haven Drive	1	21122				U.S.A		
	Itam Itam	-une	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 ☑ Married  1 □ Yes 2 ☑ No	13. V	Was Decedent of His f Yes, specify Cubar	spanic Origi n, Mexican,	Puerto R	ican, etc.)	14. Race - Black,	White,	
920	urs af	by	1 □ Yes 2 No 1 □ Yes 2 No 1 □ Yes 2 No 1 □ Yes 2 No 1 □ Yes 2 No 1 □ Yes 2 No 1 □ Yes 1 □ Yes 2 No 1 □ Yes 2	1	1 ☐ Yes 2 🕱 No	Specify:			Specify:	Wh	ite
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Itams 23s or 28s-1 show he Modical Examinational be modified at	Completed	15. Decedent's Education 16: (Specify only highest grade completed)	a. Decec	ient's Usual Occupa	tion	of working	16	b. Kind of Busi	ness/Ind	dustry
2	ithin 7	nple	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done di OO NOT use retired)	unig most	or working	,			
2	led w lygier har th		9	Hor	nemaker				Own He		
and	d 2 should be filed within 7 th and Menial Hygiene. 77 Is marked othar than "r treumatic event, ILL M.	Be	17. Father's Name (First, Middle, Last) Francis Joseph Scally					First, Middle, Ma	iden Sumame)		
Ë	hould d Me mark matic	T <sub>o</sub>		h Mailir	g Address (Street at			Flynn	ih or Tour St	ate Zie	Code
Ma	nd 2 s lth an 27 ls				7 Linthi						
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Itams 23s or 28a-f show any injury or othar treumatic event, the Modeal Examination was been confined at once.		20a. Method of Disposition 20b. Place		sition (Name of natory or other place		Da		c. Location - Ci		
Ë	Page ient o nt: If ry or		Durial 2 Contraction 3 Chamboan non State		nedral C		6/06	5/06 B	altimo	aro.	MD
alti	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee	22	. Name and Address	of Facility	G.J.	Gonce	Funera	a1 I	Home, PA
<u>m</u>	8858		Jul h		9 Rivie					MD	21122
	Physician /Medical Examiner	ler	23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a	e of):	He al	Fai Tai	) 45R	Coos			Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  C.  Due to (or as a consequence	∍ of):							
P.O. Box	that the death certifica led by the attending ph detached for use as t	Physiclan/Medlcal	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnancy Other (specify)				23d. Date of Month		ry Day Year
	w requires that been signed t should be deta	by	Part II. Other significant conditions contributing to death but not resulting	in the un	iderlying cause giver	n in Part I.		23e. Did tobac	_	ute to th	e cause of death? ably 4 Dunknown
Vital Records,		Completed						24a. Was an autopsy performed	prid dea	r to con ith?	psy findings available inpletion of cause of
<u> </u>	Physician: r this certifica ral director, i	o Be	25. Was case referred to medical examiner?		Other			Check only one)			Daughters
Division of	는 는 E	$\vdash$	1 Tes 2 Inpatient 2 ER/O	Outpatient Time of Injury	28c. Injury	4 🗀 14013	28	5 ☐ Residenc d. Describe how		(Specify	Home
Divis	tel or Attanders after death	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, f building, etc. (Specify)	arm, stre	eet, factory, office		28	f. Location (Stree City or Town, S		or Rural	Route Number,
	To the Hospitel or Attanding I within 24 hours after death. To tha Funaral Diractor: After completely filled in by the funer	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge to the basis of examination a and manner stated.	je, death nd/or inv	estigation, in my opi	nion, death	place, an	at the time, date	and place, and	due to	the cause(s)
	With To	2	29b. Signature and title of certifier	/	29c. License	number	٠,٠٠٠	29d.	Date signed (/	vionth, L	Day, Year)
	<		1 Suddelle			5/1	5/		yne.	5	2006
U	, 6		30-Name and address of person who completed cause of death (Item 23a)  Ky SSL D S S S S S S S S S S S S S S S S S	Type, F	g, Jef D	ive,	G	lea Br	m) pd.	2	100/
	Sta <del>R</del> egistr	-	31. Date filed (Montr), Day, Year)  32. Registrar's Signature	A	marke						1

DHMH 17 Rev 1/2001

ORIGINAL

06-03687 Diane Miller

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registra Physician/ 1. Oecedent's Name (First, Middle,Last) 2. Oate of Death Month Day May 30, 2006 **Medical Examiner** Miller 1422 hrs 4a Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Baltimore N/A 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs 8 Date of Birth (MM/DD/YYYY) 9 Birthplace (State or Foreign Country) MD Months Oavs Hours Director 214.56.3417 08.13.1951 M 2 Usual Residence of Deceden 10b Count Oc. City, Town or Location 10d Inside City Limits s 23a or 28a-f show a Baltimore MD 1 X Yes 2 No hours after death with the Maryland Director 10e. Street and Number 10g Citizen of What Country 21202 USA 1131 Webb Funeral 11 Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items? 14 Race - American Indian, Black, 1 Never Married 2 Married Armed Forces? Yes Black Widowed If Yes, Give Year 1 Yes 2 No specify. Specify: à 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "rigiory or other tranumatic event, the Medical. College (1-4 or 5+) 77 Pages 1 and 2 should be filed within 72 ment of Health and Mental Hygiene.
ant: If item 27 is marked other than or other traumatic event, the Medical ondon 12th grade Kepresentative 17 Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Annie Collins William F. Miller Be 19a. Informant's Name/Relationship (Type, Print ) ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald McCra 4219 Grace Baltimore MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Motionato Zionether place) 06/14/2006 2 Cremation 3 Removal from State <del>latiawn</del> Donation 5 Other Specify Signature of Funeral Service Licenses ne Funeral Sewices Baltimore MD 21212 aughn C. Gre M0136 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical a Multiple Injuries Death Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease of high yith at in little events resulting in death) Last Due to (or as a consequence of): and Physician/Medical X AMENDED item#20b,perFH,G857,7/20/06 TI UNPENDED attending physician or use as the burial Box 68760, 23c. If yes, outcome of pregnancy 23d. Oate of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Fetal death Day Year past 12 months? 2 Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 V Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 V No 3 Probably 4 Unknown Completed has been si 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? page After this certificate ✓ Yes 2 1 🗸 Yes To the Hospital or Attending Physician: 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ပ 1 V Yes 27. Manner of Oeath 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred May 30, 2006 Pediastrian struck by motorcycle e Fuueral Director: A etely filled in by the fu Natural 1355 hrs 1 Yes 2 V No 5 Pending 2 🗸 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide determined (Specify) Local Street 900 Blk Ensor Street, Baltimore, MD 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started To the 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. May 31, 2006 Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State 0

Registra

			1 - For State Registrar	State of Many		artment rtificate			and Mer		ene	006	17942
Г	Physici	an	Decedent's Name (First, Middle, Last,							Date of Death Month	Day	Year	3. Time of Death
	/Medi		CHARLOTTE ELI		IS	,				Tune	5	2006	7:05 A <sup>M</sup>
7	Examir	er	4a. Facility Name (If not institution, give					Location of				nty of Death	
			Gilchrist Cer		and the second			Lmore	2411		Ва	ltimoı	
	Funeral Director		5. Social Security Number 6. Sec. 12	IM ANTE	n yrs. last birthday) 86 Yrs.		Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, )	/ear)	Cour	place (State or Foreign
			Usual Residence of Decedent		00				INC	v. 28,	1919	wasni	ington, DC
	yland Now		10a. State 10b. County	10	c. City, Town or Lo	ocation						1	0d. Inside City Limits
	Mar.	tor	MD Prince Ge	eorge's	Laurel								1 ☐ Yes 2 🔣 No
	or 28	Funeral Director	10e. Street and Number			10f. Zip (	Code			100	g. Citizen o	of What Cour	ntry?
	23a (	aic	9000 Briarcroft La	ane #203			20	708				USA	
	ema ema	Iner	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decede	ent of His	panic Orig	jin? (Specify	Yes or No-		lace - Americ	
36	or it	by F.	1 Never Married 2 Married	1 AYes 2 No If Yes, Give		1 ☐ Yes 2		Specify:	1 0010 11100	, 0.0.,	Spec	llack, White,	
2-0036	within 72 hours after death with the Maryland ene. Then "natural", or itema 28a or 28a-f ehow he Medical Exandrer must be notillad at	d b	3 ☐ Widowed 4 🖾 Divorced	Year or Dates:								44117	
<u>τ</u>	n 72 "nai	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	(Give	dent's Usual kind of work DO NOT use	done di	tion uring most o	of working	16	ib. Kind of	Business/Ind	dustry
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Ö	Hyg other	Be C	17. Father's Name (First, Middle, Last)					18. Mother	r's Name (Fi	rst, Middle, Ma			,
a	lid be Venta Ked	To 8	Thomas Francis	S Curtin, S	r.			Eva	a Mae	Darcey		•	
Maryland	shot and h	-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Address (	Street ar	nd Number	r or Rural Ro	ute Number, C	City or Tow	m, State, Zip	Code)
Σ	and 2 salth :		Carole E. Pyle/Da	aughter	5810	) Mapl	e Te	errace	e, Lau	rel, MI	20	707	
Baltimore,	permit. Pages 1 and 2 should be itied within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if tiem 27 is marked other then "natural; or itema 23a or 28a-f show any injury or other treumatic event, the Medical Exandrae must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	amount from State	Ob. Place of Dispo cemetery, crer	sition (Name	e of ner place	)	Date	20	c. Location	n - City or To	wn, State
Ě	Pag ment ant: t		4 □ Donation 5 □ Other (Specify)	omova nom otato	Rock Cree				6/8/20	06	√ashi	ngton,	DC
a	ormit.		21. Signature of Funeral Service License	90	22	. Name and	Address	of Facility	Don	aldson	Fune	ral Ho	ome, P.A.
	g0 = 9 9		James of	1 ACC						Laurel		20707	
			23a. Part1. Enter the disease, or compli- shock, in heart failure. List only on	cation, that caused the ease on each line.	death. Do not ent	er the mode	of dying,	, such as ca	ardiac or res	spiratory arrest			Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a co	nsequence of):				1				
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-d	certificate be executed Iding physician and Ise as the burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a cor	nsequence of);								
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X OR	eath certific attending p	N/u	IF FEMALE: 23b. Was decedent pregnant	Bc. If yes, outcome of pr							23d. D	ate of deliver	rv
	death ed for u	sicia	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown		Ectopic preg Other (spec					N	Month	Day Year
j L	that the the ded by the detacher	by Physician/Med	9 ☐ Unknowh		-		-	-110	-				
ś			Part II. Other significant conditions con	tributing to death but no	t resulting in the ur	derlying cau	ise given	in Part I.		23e. Did tobac	co use cor	ntribute to the	e cause of death?
cords,	requires een sign rould be	Completed								1 ☐ Yes	2 D4No	3 Proba	ably 4 □Unknown
d)	as b	npie							:	24a. Was an autopsy	24b	. Were autop	sy findings available inpletion of cause of
	certificate has rector, page 2	Co							1	performed Yes 2∑		death? 1 ☐ Yes	
VITAL	r this certific	Be	25. Was case referred to medical examiner?	ospital:			100		of Death Ch	eck only one)			
5	this ald	2	1 Yes 2 No	1 L Inpatient	2 ER/Outpatient			4   Nursi		5 Residenc		ther (Specify)	nospia
ב ו	After funer	i E	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	M 280	Work?		1	Describe how i	njury occu	irred	
VISION	deat deat ctor: y the	lica	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury	At home farm stre			s 2 No		anation (Street	A = = = d A (		
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			29a. Certifier 12-Certifying Phys	ician: To the best of my	knowledge, death	occurred at	the time.	, date and r	place, and d	lue to the cause	e(s) and m	anner as sta	ted
3	in 24 I	edicai	(Check only 2 Medical Examin	er: On the basis of exar and manner stated.	mination and/or inv	estigation, in	my opin	nion, death	occurred at	the time, date	and place	, and due to	the cause(s)
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	5			MES un	6601 1	Print) V. CC	ier le	25 5 +	- 392	nuon	L U	0 2	1204
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Vuestro, Andrea

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 19b per fh 8856 6-7-06 yt. State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** ANIDREA NUESTRO 2006 /Medical June 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LEVINDALE HEBREW HOME BALTIMORE If Under 1 Year
Months Days 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Min 1□M 2□F Yrs. Director NONE 88 1/10/1917 PHILIPPINES Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or items 23a or 28e-f show other treumetic event, the Medical Examinat must be notified at N/A MD BALTIMORE Director 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2434 W. BELVEDERE AVENUE 21215 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or Items 23s any injury or other treumetic event, It a Mudical Examinat must once. PHILIPPINES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: à WHITE Specify 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CAREGIVER CHILDREN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) UNOBTAINABLE UNOBTAINABLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HANNAH KUHR / FRIEND 2510 TANEY ROAD - BALTIMORE, MD <del>21215-</del> **2120**9 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
DULANEY VALLEY
MEMORIAL PARK 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 06/06/2006 TIMONIUM, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CORONARY ARTERY DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the design of the cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner ed by the attending physician and detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 requires that the death certificate be Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 22 No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 1 Natural 5 Pendina To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D054739 Donna YV 5th 2006 JUNE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue Belvedere Balamore Maryland 21215 W)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

32. Agistrar's Signature

		1 - State Registrar	State of	Maryland		artment <i>rtificate</i>			and M	lental Hyg	iene 2 (	006	1794	
C ph. S		1. Decedent's Name (First, Middle, Las	st)			-				2. Date of Dea Month		V	3. Time of Death	_
Physicia /Medic		Barry Eugene	Pearl							June	-	Yeer 006	5:30 A	М
Examin		4a. Facility Name (If not institution, give	street and numb	ber)		4b. City, 1	own, or	Location o	of Death		4c. Count	y of Death		
	100	Prince George's	Hospital	Center	:	Ch	ever	rly			Prin	ce Ge	eorge's	
, Funeral		Social Security Number     6. Security Number	ex 7. ⊠M. 2 □ F	. Age (In yrs. las			Year Days	If Under	24 Hrs. Min.	8. Date of Birth	Yearl	9. Birth	place (State or Forei	gn
Director		21/-44-525/	MIN SOL	60	Yrs.					May 18	1946		nington, I	)(
and and	}	Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Lo	cation							10d. Inside City Limi	
f ehc	0	MD Prince G	oorgo!s		Bowie								1√2 Yes 2 □ N	
286 286	rec	10e. Street and Number	corge 5		DOWLE	10f. Zip (	^ode			1	0g. Citizen of	What Carr		
With With	٥	14958 Nashua Lane				101. 210		716		'	_	SA	nury ?	
De lied within 72 hours after death with the Maryland ital Hygiene. Ital Hygiene. Ad other than "natural", or Itame 23a or 28e-f show event, the Medical Examiner must be rediffed at event,	Funeral Director	11. Marital Status	12. Was Decede	ent Ever in U.S.	13.	Was Decede			ain? (Spe	ecify Yes or No-			can Indian.	_
of Ital	Ē	1 Never Married 2 Married	Armed Forc	es? □ No				n, Mexican	, Puerto	ecify Yes or No- Rican, etc.)		ck, White,		
Exall, o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	es:		1□Yes 2	No.	Specify:			Specia	y: Whi	ite	
natur Ilgal	Completed	15. Decedent's Ed (Specify only highest grad	ucation		16a. Dece	ent's Usual	Оссира	ition	- ( - 1		16b. Kind of B	usiness/In	dustry	-
than "	pje	Elementary/Secondary (0-12)	College (1-4	lor 5+)	life.	kind of work DO NOT use	retired)	uring most )	or worki	ng				
Hygiene.	5	12th	Ø		Home	Insp	ecto	r			Self	-Empl	oyed	
tal Hygie d other t	Be	17. Father's Name (First, Middle, Last)						18. Mothe		(First, Middle, M		ne)		
marked o	၀	Abraham Pearl							Mar.	ie Golds	tein			
E # E	1	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	ng Address (	Street a	nd Numbe	r or Rura	l Route Number,	City or Town	State, Zip	Code)	_
f Health Item 27 I	- 1	Lucy Pearl/Wife			-			ane,	Bow	ie, MD 2	0716			
		20a. Method of Disposition  1XXBurial 2 Cremation 3	Removal from Sta		ce of Dispo netery, crer	sition (Name	e of er place	9)	C	ate	20c. Location	City or To	own, State	
Department of Important: If It any injury or o once.		4 □ Donation 5 □ Other (Specify			Leban	on Ce	mete	ery   6	5/7/:	2006	Adelph	i, MD	)	
Department Important: I any injury o		21. Signature of Funeral Service Licens	see		22	. Name and	Address	s of Facility	Dona	aldson F	uneral	Home	P.A.	-
الاققطات		tanices	11 book	) M0110	3 3	13 Ta	lbot	t Ave	enue	, Laurel	, MD	20707	•	
hysician Medical xaminer the private the private the private transit	ai Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. End Due to (or c. Dia	as a consequent as a consequent as a consequent	nce of):	Rev	•	d	ise	ssion 45			ý	
ueant certificate be executed e attending physicien and od for use as the burial-transit	edicai		d											_
ed by the attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 ☐ Fetal de t at time of deatl	eath 3	Ectopic pred						te of delive	ory Day Year	
	Dy P	Part II. Dther significant conditions co	ntributing to deat	h but not resultir	ng in the ur	iderlying cau	ise giver	n in Part I.		23e. Did tob	acco use cont	ribute to th	e cause of death?	
										1 ☐ Ye	s 2 No	3 🗌 Prob	ably Unknown	١
s been s	Completed									24a. Was an	24h 1	Nore autor	osy findings available	_
page 2	E									autopsy	ed?	prior to cor leath?	npletion of cause of	,
certificate rector, pag		25. Was case referred to medical										Yes	2 No	_
s cer firect	0	examiner?	Hospital:	atient 2 ER	/Outpatient	3 □ DOA	Other			Check only one		4.5		-
eral c	-	27. Manner of Death	28a. Date of I		b. Time of		. Injury a	at		ne 5 Resider			"	
fun führ.		Natural 5 Pending 2 Accident Investigation	(Month, i	Day Year)	Injury	м	Work?	es 2□N			,,	00		
within 24 nours after death.  To the Funeral Director. After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined	28e. Place of building,	Injury - At home etc. (Specify)	, farm, stre	et, factory,				8f. Location (Stre City or Town,	eet and Numb State)	er or Rura	l Route Number,	
Funera Funera itely fille	Medical	29a. Certifier (Check only one)  (Check only one)	mer. On the basis	s of examination	dge, death and/or inv	occurred at estigation, in	the time	, date and nion, death	place, a	nd due to the cau	use(s) and ma	nner as sta	ated. the cause(s)	_
thin the the mple	Ae.	29b. Signature and title of certifier	and manner	stated.			icense							
F 8		^	aras!	M. r	)				,	29	d. Date signed		vay, rear)	
1				ートピン				104			الرواء	50		
10		30. Name and address of person, who co		of death (Item 23	Sa) (Type, F CK U	rint)	MA	20	85	2				
		31. Date filed (Month, Day, Year)		strar's Signature		- 11-	. 11	للب	-	-	201-2			
State		HN 0 7 200	C	- Signature	1	. N. 0								

06-03824 Please Type or Print in Black Indelible Ink Paul L. Pate State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day June 4, 2006 1727 hrs Medical Examiner Paul L. Pate 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Maryland General Hospital Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or **Funeral** Foreign Director Months Days Hours Min. 292-72-2219 07/23/1971 1 X M 34 Country) Ohio 2 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show notified at once. Md N/ABaltimore 1 X Yes 2 No jes I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1702 Linden Avenue 21217 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes If Yes, Give Year 3 Widowed 4 Divorced Specify: Black 1 Yes 2xx No specify: þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Computer Specialist Self Employed If item 27 is marked other 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Paul L. Pate, Sr. Karen Michael 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Pate 1702 Linden Avenue, Baltimore, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, crematory or other place) Burial 2 XCremation 3 Removal from State permit. Pager Department of Important: Metro Crematory 8/7/2006 Baltimore, Md. Donation 5 Other Specify 22. Name and Address of Facility Estep Brothers Funeral Svc grature of Funeral Servi Lice 1300 Eutaw Place, Baltimore, Md. d ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Enter the disease, or complications that ca failure. List only one cause on each line Between Onset and /Medical Death a. Pulmonary Thromboembolus Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b. Right leg deep vein thrombosis Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical attending physician or use as the burial UNPENDED AMENDED Box 68760, 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year past 12 months? Pregnant at time of Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o è ے 1 Yes 2 No 3 Probably 4 V Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? ✓ Yes 2 N 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be Other: Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 this 1 🗸 Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 V Natural Division 1 Yes 2 No Pending the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 24 hours after 3 Suicide Could not be determined Fo the Funeral 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 5, 2006 30. Name and address of person who completed cause of death (Item 23a) d

State Registrar

OCME 2006

DHMH 17 Rev 1/2001

Zabiullah Ali, M.D.

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31. Date filed (Month, Day Ye

Assistant Medical Examiner

32. Registrar's Signature

BUREN.

111 Penn Street, Baltimore, MD 21201

		1 - For State Registrar	State of	Marylar				ealth a Death	and M	ental Hyg	iene g. No.	006	17946
Physici /Medic		1. Decedent's Name (First, Middle, Last	Petri							2. Date of Deat Month	Day	Year 2006	3. Time of Death
Examin		4a. Facility Name (If not institution, give	-	rber)	Courte	4b. City	,	Location of				ounty of Dea	
Funeral Director		5. Social Security Number 6. S 218-03-0579		7. Age (In yes	. last birthday) 87 <sub>Yrs.</sub>	If Unde Months	r 1 Year Days	If Under Hours		8. Date of Birth (Month, Day, 1-19-1	Year)	9. Bi	rthplace (State or Foreign country)
pu »		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation				1 12 1		1.3%	10d. Inside City Limits
ne Maryli 8e-1 sho	Director	MD BALT	IMORE		,			ROS	SEDAI				1 ☐ Yes 2 ☐ No
th with the	ai Dir	10e. Street and Number 1335 EVERING A	VENUE			10f. Zij		1237		11	0g. Citize	un of What C	
ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene.  I of Health and Mental Hygiene.  I of Health and Mental Hygiene.  I other treumstic event, the Medical Examiner out the notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Dece Armed For 14 Yes If Yes, Give Year or Da	dent Ever in Uces? 2 No tes: 1943		Was Dece If Yes, spe 1  Yes		spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto	ocify Yes or No- Rican, etc.)		Black, Whi	erican Indian, ite, etc. VHTTE
ithin 72 ho	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		4or 5+)	life.	kind of wo DO NOT L	ork done d se retired,	luring mosi }	t of worki	ng		of Business	•
filed w Hygier other th	a)	12 17. Father's Name (First, Middle, Last)		<del> </del>	S	TEAM	TTTE		r's Name	(First, Middle, N		ONSTRU umame)	CTION
ould be Mental narked	To B	WENDELL A.	PETE	RI				MAF		ANNA		(SMITH	
and 2 sh lealth and m 27 is m		19a. Informant's Name/Relationship (19mm) MADELINE HANSEN/Date   19mm)				-		AVENU		PARKVIL			Zip Code) 21234
permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other tre		20a. Method of Disposition 1 Surial 2 □ Cremation 3 □	Removal from S	itate	Place of Dispo cemetery, crer	natory or	other place				20c. Loca	tion - City or	Town, State
permit. Pa Departmen Importent: any injury		* 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	<u> </u>	HC	OLY RED					2006 CH/ROSEI		TIMORE FUNER	•
Dermi Depa Impo any is		23a. Part1. Enter the disease, or comp			- 1	211 (	HESA	CO AV	ENUE	ROSI	EDALI	E, MD	21237
Physician /Medical Examiner  the prival-transit  the prival-transi	dicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Exist Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (c	or as a consector as	quence of):	trte	3	Dise	agi				Onset and Death
The law requires that the death certificate be executed site has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 Feta	al death 3□	Ectopic p Other (sp					230	d. Date of de Month	livery Day Year
quires that in signed b	by	Part II. Other significant conditions of	ontributing to dea	ath but not res	sulting in the u	nderlying o	ause give	in in Part I.			acco use		o the cause of death?
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Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital: 1 □ In	patient 2	] ER/Outpatien	t 3 🗆 D0	Othe	e 6		(Check only one		Other (Sne	orfu)
or Attending Ph Inter death. Director: Atter thi in by the funeral	ation: T	27. Manner of Death   Natural 5   Pending     Accident   investigation		Injury , Day Year)	28b. Time of Injury		8c. Injury Work	-	2	8d. Describe ho			0.197
To the Hospitel or Attending Is within 24 hours after death to the Funerel Director: Atler completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	286. Place (	of Injury - At h g, etc. <i>(Speci</i>	iome, farm, stre fy)	eet, factor	, office		2	8f. Location (Str. City or Town,	eet and N State)	lumber or Ri	ural Route Number,
e Hospit 24 hours Funere letely fille	edical C	29a. Certifier Certifying Ph (Check only one) /2   Medical Exam	ysician: To the lainer: On the bar and manne	sis of examina	owledge, death ation and/or inv	occurred restigation	at the tim , in my op	e, date and inion, deat	d place, a	nd due to the car d at the time, da	use(s) an te and pla	d manner as ace, and due	s stated. e to the cause(s)
To th within To th comp	Me	29b. Signature and title of certifier				29	. License	number	2 ( / >				h, Day, Year)
in		30. Name and address of person when	ompele cause	of death (Iter	m 23a) (Type.	Print)	7)	1057	145		une	5 2	COUL
1/		Ndidi Fember	3 560	14/00	Rave	BIV	J BO	3#30	3 6	Baltmar	2 /	up z	21239
Sta Registr	-	31. Date filed (Month, Day, Year)	32,710 DS	gistrar's Signi	ature do	antie)							

			1 - For State Registrar	State of Ma	arylan			of Health a			giene Reg. No	0000	1701.7
	Physici		Decedent's Name (First, Middle, La Marv	Elizabeth	1		Randa	i11		2. Date of Dea Month June 1.	ath Da	v Year	3. Time of Death 7:15AM M
	/Medic Examir		4a. Facility Name (If not institution, gir Asbury - Solor	ve street and number)				own, or Location	of Death	oone 1	4c	. County of Death Calvert	
EMERGO, ON	Funeral Director	2		Sex 7. Ag 1□M 2□F 9]		last birthday) Yrs.	If Under 1		24 Hrs. Min.	8. Date of Birth (Month, Day May 26			place (State or Foreign Intry) York
ryland	thow tel		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
ith the Ma	or 28e-1 s	Directo	Maryland Calvert			North 1	Beach 10f. Zip C	code	-		10g. Cit	izen of What Cou	1 ☐ Yes 2√ No Intry?
Yland 21215-0036 ould be filed within 72 hours after death with the Maryland	od Mental Hygjene. marked other than "natural", or itame 23s or 28e-1 show imatic event, the Medical Examinar must be notified at	by Funeral Director	P.O. Box 363  11. Marital Status  1 Never Married 2 Married	12. Was Decedent Armed Forces? 1  Yes 2 XX		l1		714 nt of Hispanic Ori y Cuban, Mexicar No Specify:		crfy Yes or No- Rican, etc.)		.S.A.  14. Race - Amer Black, White Specify: Wh	
Maryland 21215-0036 d 2 should be filed within 72 hours af	ne. han "natural' e Medical Ex	Completed b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	Year or Dates: ducation ade completed) College (1-4or 5	5+)	(Give life. L	OO NOT use	done during mos retired)		ng		ind of Business/Ir	
land 27	fental Hygie rked other ti tic event, Ita	To Be Co	12th  17. Father's Name (First, Middle, Lass Patrick Shann			Contra	acting		er's Name	(First, Middle,	Maiden		vernment
C S	DE E		19a. Informant's Name/Relationship Kathleen Waltha	<i>Туре, Print)</i> 111 (Daught	er)	19b. Mailin	g Address (S P.O.	Street and Number Box 363	er or Rura Nort	<i>Route Numbe</i> h Beach	r, City o	or Town, State, Zi, aryland	o Code) 20714
Baltimore, permit. Pages 1 ar	Department of Health a Important: If Item 27 is any Injury or other tra		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci			lace of Disposemetery, cren Surrect		of erplace) emetery	Jun 200	e 5,		ocation - City or T	
Balti permit.	Departri Importa any Inju		21. Signatur Funeral Service Lice	I moo		(	6633 0	Address of Facilit	<sup>by</sup> Le	e Funer Ferry	al I Road	Home, In	c. n. MD20735
	ysician Medical		23a Part. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a.C.O.M.L	10. 1 CAT	76~5		LZHEM				155	Approximate Interval Between Onset and Death
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8760, cate be executed	ohysicien and the burial-transit		resulting in death) Last	Due to (or as	a consequ	uence of):							
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ecords, P.O law requires that the	been signed by the s should be detached t		Part II. Other significant conditions	ontributing to death be	ut not resu	ulting in the un	derlying cau	se given in Part I.	,	23e. Did to		se contribute to t	he cause of death?
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	is certifi director	o Be	25. Was case referred to medical examiner?  1 Yes 2 You	Hospital: 1 ☐ Inpatie	at 201	ER/Outpatient	4E 804	011		(Check only on			
Ion of			27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	v	28b. Time of Injury		Injury at Work?	2	8d. Describe ho		Other (Specify occurred	(y)
DIVISION tel or Attending	within 24 hours after death.  To the Funerel Director: After the completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined		ury - At ho	me, farm, stre	et, factory, c	office	2	8f. Location (St City or Town	treet and n, State	d Number or Rura )	al Route Number,
ne Hospi	n 24 hour he Funer bletely fills	Medical (	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	nysician: To the best on niner: On the basis of and manner sta	examinat	wledge, death ion and/or inv	occurred at estigation, in	the time, date an my opinion, deat	d place, a th occurre	nd due to the cad	ause(s) late and	and manner as s place, and due to	tated. the cause(s)
Totl	To t	Σ	29b. Signature and title of certifier	el				icense number	18			e signed (Month,	* * * * * * * * * * * * * * * * * * * *
	8		30. Name and address of person who John H. Weigel				Print)						
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra 2005	ar's Signat	ure A	Sala	rederic!	k. Ma	ryland	206	/੪	

State of Maryland / Department of Health and Mental Hygiene 1 1 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year PM War /Medical une 006 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death Baltimore Bayview n/a Care Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral**  Birthplace (State or Foreign
Country) MM 2□F Months Days Hours 60 Director 212-44-6814 Md. Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City. Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Mudical Examinary ust be notified at Md. Baltimore Dundalk 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? neturel', or items 23a or 2905 Dunmore Rd. Apt. B 21222 USA death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 ☐ Widowed 4 X Divorced Year or Dates: Completed permit. Pages 1 and 2 should be filed within 72 h. Department of Health and Mental Hyglene. Important: If item 27 is marked other then "netu any injury or other treums": 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 yrs. College (1-4or 5+) Truck Driver Tranportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward Rasel Sr. Pauline Cappelli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline Rasel 3119 Shortway mother Dundalk Md. 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State June 8 Baltimore \* 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 2006 Signature of Foreral Service Licensee 22. Name and Address of Facility.
Connelly Funeral Home of Dundalk
7110 Sollers Point Rd. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MetaStati disease or condition resulting in death) Yea /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death Day 5 Other (specify) signed by the a Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has Brancho certificate 25. Was case referred to medical examiner? 1 Yes ≥√2 No 1 Tyes 2□ No or Attending Physicien: funeral director, To Be 26. Place of Death (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide within 24 hours a

To the Funerel I

completely filled Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 2424 June who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe 5505 NO W:113am 31. Date filed (Month, Day, Year) 32 egistrar's Signature State Registra

			1 - For State Registrar		State o	f Marylar			t of Health e <i>of Death</i>		-	- /	006	170	)4
			Decedent's Name (First,	Middle, Las	r)		-	imour	o or beatr	<u>,                                     </u>	2. Date of De	Reg. No.		3. Time of D	eath
	Physic		Minnie		M.	Rob	inc				Month 06	Day 05	Year	11:54	
	/Medi Examir		4a. Facility Name (If not ins	titution, give	street and num		(11)	4b. City,	Town, or Location	of Death	00		06 unty of Death	11177-1	
			Franklin Squu	are H	nepita	Centa	2.1	RE	sedal	٥		Bo	Himor	.0,	
	Funeral		5. Social Security Number	6. Se	×	7. Age (In yrs.		If Under	1 Year   If Unde	r 24 Hrs.	8. Date of Bir (Month, Da	th	9. Birtho	place (State or F	Foreign
	Director		234-46-9021	1[	⊒м 2√2 F	· ·	76 Yrs.	Months	Days Hours	Min.	12-21-	y, Year) -1929	WES?	ntry) !' VIRGIN	NIA
	pu a		Usual Residence of Deceder 10a. State 10b. C			100 0	h. Tour as la								
	aryla •ho	5	MD		TIMORE	100. 01	ty, Town or Lo		EDALE				1	10d. Inside City	
	the Maryland r 28a-f ehow	Director		שמט										1 □ Yes 2	TVI00
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	efter deeth with or Iteme 23s or mitter must be	by Funeral	6404 HAZELV	VOOD A		dent Ever in U	S 12.1	Man Daged	21237		-# . V N	14	U.S.A.		
10	ter dee	ä	1 Never Married 2	Married	Armed For	rces?	.3.	If Yes, spec	ent of Hispanic Or ify Cuban, Mexica	n, Puerto F	Rican, etc.)	- 14.	Race - Americ Black, White,		
036	ours eft	þ	3 XWidowed 4 ☐ Div		If Yes, Giv Year or Da	0		1□Yes 2	No Specify	:		Spe	ecify: WH	HITE	
0	72 hours "natural"	Completed		edent's Edu		-	16a. Deced	dent's Usua	Occupation			16b. Kind o	of Business/Inc	dustry	
215	within 7 ene. than "r	ple	(Specify only Elementary/Secondary (C		College (1	-4or 5+)	life.	DO NOT us		st of workin	ig			,	
· 52	er th	S	Elementary/Secondary (0					FAC	TORY				SOAP		
<u> </u>	d oth	Be	17. Father's Name (First, M	iddle, Last)					18. Moth	er's Name	(First, Middle,	Maiden Sun	name)		
Minn	Meni Meni arke	ပ	GEORGE			NIC	KOLES			IARY			FISHER	•	
Z ≥	2 sh and le m	100	19a. Informant's Name/Rel						(Street and Numb						
Robins, Minnie Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur eny injury or other treumatic event, the Madical ADES.		ROBERT SCHM	117/50		005			WOOD CIF			LIN, V		3132	
ore	H it of H		20a. Method of Disposition 1   Burial 2   Crema	ation 3 □F	Removal from S		lace of Dispo emetery, cren	natory or ot	her place)		ate	20c. Location	on - City or To	wn, State	
ting.	t. Partmer		4 Donation 5 Oth			OAI	KLAWN (		- 1	6-9-2			'IMORE,		
Bal	Depariment of the parameter of the param		21. Signature of Funeral Se	rvice Licens	•• ()_	1			Address of Facili						
			220 Posts Foliation disco						HESACO A			OSEDAI	E, MD	21237	<u>'</u>
			23a. Part1. Enter the disea shock, or heart failure	List only o	ne cause on ea	ich line.	n. Do not ent	er the mode	of dying, such as	cardiac or	respiratory ar	rest,		Approximate Interval Betwee	
	Physician		Immediate Cause (Final disease or condition resulting in death)		Sep	515							1	Onset and Dea	Itu
	/Medical Examiner		rosamig in doam,		Due to (	or as a conseq	uence of):								
		<u></u>	Sequentially list conditions,		CO11	+15	anne elle								
W	nsit	Examiner	Sequentially list conditions, 1 and	~	Coessi	A de a our may	worker only:								
1	executed in and ial-transit	xar	that initiated events resulting in death) Last	,	Due to (c	or as a consequ	uence of):								
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587	ficate physics the	edical			1										-
Вох	Physician: The law requires that the death certific this certificate has been signed by the attending rail director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnar	at 2	3c. If yes, outo	ome of pregna	ncy					224	Data of dation		
ĕ	d for	clai	in the past 12 months?	11.	1 ☐ Live bit	nth 2 ☐ Fetal ant at time of de	death 3	Ectopic pre Other (spe					Date of delive Month	ry Day Yea	ır
P.O.	the cy by the	lys	9 Unknown		9□ Unkno										
	signed k	by P	Part II. Other significant co	nditions cor	ntributing to dea	ath but not resu	ulting in the un	nderlying ca	use given in Part I		23e. Did to	bacco use c	ontribute to the	e cause of deat	:h?
ş	quire n sig uld bu										1 🗆 Y	es 2 No	3 ☐ Proba	ably 4 ∐Unkr	nown
ဝွ	s been s	Completed									24a. Was a	24	h Ware auton	ev findings ava	ulabla
Re	The lav	mo									autop	sy med2/	prior to com death?	sy findings avai	e of
ta	ician: Th certificete ector, pag		25. Was case referred to me	edical					00.01-	-10 11	1 Yes		1 ☐ Yes	2 No	
Division of Vital Records,	ysician: is certific director,	ToB	examiner? 1 Tes 2 No	_	lospital:	patient 2	ER/Outpatient	t 3 DOA	1 Oth		Check only or	-			
9	g Ph er thi		27. Manner of Death	-	28a. Date of		28b. Time of		c. Injury at Work?		e 5 Resid			)	
<u>.</u>	Attending P r death. ector: After by the funera	ato		ending vestigation	(Month	, Day Year)	Injury	м	Work? 1 ☐ Yes 2 ☐	i		,-,			
<u>×is</u>	I or Attendi after death Director: A i in by the fu	<u>=</u>	3 ☐ Suicide 6 ☐ C	ould not be	28e. Place	of Injury - At ho	me, farm, stre	et, factory,	office	28	f. Location (S	treet and Nu	mber or Rural	Route Number,	
ä	al or A	Certification:	4 🗀 Homicide		buildin	g, etc. (Specify	')				City or Tow	n, State)			
	Hospital 24 hours a Funerel I etely filled	la l	29a. Certifier 1 Cer	tifying Phys	sician: To the t	est of my know	wledge, death	occurred a	t the time, date an	d place, an	d due to the c	ause(s) and	manner as sta	ated	-
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	one) 2 I Mee	icai Examii	and manne	ois or availillar	ion and/or inv	estigation, i	n my opinion, dea	th occurred	at the time, d	ate and plac	e, and due to	the cause(s)	
•	To the I		29b. Signature and title of ce	ertifier	7			29c.	License number		2	9d. Date sign	ned (Month, D	Day, Year)	
J				V				D	3761	2		6/5/	RI.		
	5		30. Name and address of pe	rson who co	mpleted cause	of death (Item	23a) (Type, F	Print)	V / U	-		0 1 1/	00		
			Dr. Moham	adi	Habro	rsh 9	000 F	Fank	lin Samo	TE D	Tive A	altim	Mr sa	2/23	7
1	Sta		31. Date filed (Month, Day,	(ear)	32. Re	gistrar's Signat	ure			Milder .			a up it		
	Registra	ar	.HIN	0 7 21	106	Posterio a	16 1	nash	2						

Physic		1 - State Registrar Amend #10e Per FH G856 6/07/Gertifficate of Death  1. Decedent's Name (First, Middle, Last)  JOAN F. REHAK	2. Date of D Month JUNE	3, 2006 Year	3. Time of Death 1:15 P. A
/Medi Exami		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location		4c. County of Dea	
		1029 HART ROAD TOWSON			TIMORE
uneral irector		5. Social Security Number 212-30-9396 6. Sex 1 $\square$ M 2XXF 7. Age (In yrs. last birthday) 1ft Under 1 Year If Under 1 Year   Ho	8. Date of Bi (Month, D 06-30-	(ay, Year) C	rthplace <i>(State or Foreig</i> foun <i>try)</i> MARYLAND
3		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	00 30	1550	
fied at	to				10d. Inside City Limit 1 ☐ Yes 2 X X
N N	Olrec	10e. Street and Number			•
MD. BALTIMORE TOWSON  1   Yes 2   1   1   1   1   1   1   1   1   1					
	by	If Yes, Give 1 ☐ Yes № No Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Black, Whi	te, etc.
	lete	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during mo	ost of working	16b. Kind of Business	s/Industry
	omo	Elementary/Secondary (0-12)  College (1-4or 5+)  4 YEARS  HOUSEWIFE		OWN H	IOME
	Be	17. Father's Name (First, Middle, Last)  18. Moth			
	L <sub>C</sub>				Zip Code)
		MATTHEW J. REHAK (HUSBAND) 1029 HART ROAD, TO			
		XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Cemetery, crematory or other place)  DULANEY VALLEY M.G.	06-07-2006	TIMONIUM,M	IARYLAND
				TNIC	
Ţ		77.75		LONZON	Approximate
	Immediate Cause (Final disease or condition resulting in death)  a. Probable arterioscleration  Due to (or as a consequence of):			Onset and Death	
	Ical	Due to (or as a consequence of):  d			V
	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1		23d. Date of de Month	livery Day Year
	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part		tobacco use contribute to	
	letec	Mild acrtic stenosis	24a. Was		robably 4 Unknow  utopsy findings available
	Completed	Dermotomyositis + chronic low dose predn	auto	psy prior to death?	completion of cause of
	Be	25. Was case referred to medi a examiner?	e of Death Check only	one	
	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		idence 6 Other (Spe	cify)
	Certification:	X(X)Natural 5 ☐ Pending   (Month, Day Year)   Injury   Work?   2 ☐ Accident   Investigation   M   1 ☐ Yes 2 ☐   3 ☐ Suicide   6 ☐ Could not be determined   28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	]No	Street and Number or Ru	ural Route Number,
	edical Cer	29a. Certifier  (Check only 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, de.	nd place, and due to the	Cause(s) and manner as	s stated, to the cause(s)
	Mec	29b. Signature and little of certifier  Acris E. Mielsen, MD  29c. License number marulan  29c. License number marulan  27c. License number numb		JUNE 5, 2	
		1 1/21/21/21			
completely lilled in by the		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  LOIS E. NIEZSEN MD, 120 SISTER PIEA  31. Date filed (Month, Day, Year)  32. Registrar's Signature	RRE DR. #	206; TOW.	SON, MD

			1 - For State Registrar	State of Maryla	nd / Depa		ealth and Me	ental Hygien	2005	17951
	Physici /Medi Examir	cal	Decedent's Name (First, Middle, Last     Agnes Red  4a. Facility Name (If not institution, give	ling		4b, City, Town, or I		May 2	year Year 2006	3. Time of Death 12 45 Q M
-	Funeral Director		Maryland Grene 5. Social Security Number 6. Se	eral Hosp	i fall . last birthday) . 4 Yrs.	Bulfim  If Under 1 Year  Months Days	ORQ C.	B. Date of Birth (Month, Day, Yea 7. 25	N/A	place (State or Foreign
	Maryland a-f show	ctor	Usuel Residence of Decedent  10a. State  10b. County  A	10c. C	ity. Town or Loc	more				10d. Inside City Limits
	ath with the 23a or 28	Funeral Director	10e. Street and Number 2809 E. Bidd	le Street		10f. Zip Code	213	10g. C	Citizen of What Cou	ntry?
9036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "naturel", or iteme 23e or 28e-f show event, the Medical Evertine must be rotified at	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 KNo If Yes, Give Year or Dates:	ĺ	Vas Decedent of His Yes, specify Cuban ☐ Yes 2 No	panic Origin? (Spec , Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Americ Black, White, Specify:	
121215-0036	filed within 72 h Hygiene. kher than "nati int, ine Medici	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	(Give )	urses A	ring most of working		Kind of Business/In	ıl
Maryland		To Be	17. Father's Name (First, Middle, Last) Willie Fleming	no Bright Carolina	10h Mailin		Hatie	First, Middle, Maide		
	1 and 2 and 2 and 2 and 27 le		Deborah A. Kith  20a. Method of Disposition	rell/Daughter	9701	Overvie	n Court			MD 20744
Baltimore,	permit. Pages Department of I Important: If Its Important or or Page Injury or or		1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	Removal from State	arden 22	of Faith	06.03	3.06 B	altimor	e MD
Ba	Deg Imp ony		23a. Part1. Enter the disease, or compl	~ M0136		400 You	Greene 1 Road	Barin	service one MD:	21212 Approximate
≥ 09289	death certificate be executed  E xx  Wedical  e attending physicien and and for use as the burial-transit	lical Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. List though a Cause (Disease or injury that infittated events resulting in death) Last	Due to (or as a consection)  Due to (or as a consection)  Due to (or as a consection)	quence of):					Interval Between Onset and Death
. Box	that the death certifica ed by the attending ph detached for use as tt	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	al death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
Ω.	quires that the signed by and be detacted	ρχ	Part II. Other significant conditions con	ntributing to death but not res	sulling in the un	derlying cause given	in Part I.		use contribute to the	1/
	n: The law requires that the icate has been signed by th r, page 2 should be detache	Completed						24a. Was an autopsy performed?	dealh?	psy findings available mpletion of cause of
of Vit	Physician: 1 r this certificat ral director, p.	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	fospital: 1 Inpatient 2	ER/Outpatient	Othon	26. Place of Death   4 □ Nursing Home	Check only one 5 Residence	6 ☐ Other (Specify	y)
ion	Attending P ir death. sctor: After t by the funera	ation;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work? M 1 🗆 Ye	al 28 es 2 □ No	d. Describe how inju	iry occurred	
Divis	2 9 2 2	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - AI h building, etc. (Special	ome, farm, stre fy)	et, factory, office	28	f. Location (Street a City or Town, State	nd Number or Rura e)	l Route Number,
	To the Hospitel o within 24 hours at To the Funerel D completely filled in	edical	29a. Certifier 1 Certifying Physical Control one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death alion and/or inve	occurred at the time estigation, in my opin	, date and place, and nion, death occurred	d due to the cause(s at the time, date an	i) and manner as st id place, and due to	ated. the cause(s)
)	To the To the comp	M	29b. Signature and title of certifier	MACHUKWI	u, MD	29c. License i		29d. Da	ate signed (Month, 5/25/(	Day, Year)
	K		30. Name and address of person who co				narulas	d Gren	eral h	Lospital
	Sta Registr		31. Date filed (Month, Day, Year)	32. Agistrar's Signa	× 6	will	J 133			

		For Stata Ragistrer	State of	Marylar	nd / Depa		t of H	ealth and Death	•		ne <sub>20</sub>	06	17952
Physicia /Medica		Decedent's Name (First, Middle, La.     DOLORES	L.		HLOSS						2 21	Year	3. Time of Death
Examine	er	4a. Fecility Name (If not institution, give Baltimore—Washing 5. Social Security Number 6. S	gton Med	ical Ce		G1	en I	Location of De Burnie If Under 24 F		of Birth		e Aru	indel  place (State or Foreign
Director		219-18-3614 1  Usual Residence of Decedent  10a. State 10b. County	□ M 2 <b>M</b> F	80	Yrs.	Months	Days	Hours M	June	16,	1925	Mar	yland
the Maryle 28a-1 eho	rector	Maryland N/A	A		Balti		Code			10g.	. Citizen of \		10d. Inside City Limits 1
death with	Funeral Director	1439 Battery Aver	12. Was Dece	dent Ever in U	.S. 13. \		2123	spanic Origin?	(Specify Yes		14. Rac	U.S.A	ean Indian,
C14 LDSS 1215-0036 within 72 hours after death with the Maryland ene. than "naturel" or iteme 23a or 28a-1 show he Madical Exeminer must be notified at	ed by Fu	1 Never Married 2 Married 3 MWidowed 4 Divorced	1 □ Yes If Yes, Give Year or Da	2 <b>2</b> No		I□Yes 2	No No	Specify:	erio nicari, etc		Specify	ck, White, v: Whi	te
21215- 21215- d within 72 Jiene. I'r than "nate	Completed by	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	College (1-	4or 5+)	iire. L	ient's Usua kind of wor DO NOT us OUSEW	k done d e retired,	uring most of	working	161	o. Kind of Br	omess/ind	Justry
Maryland 21215-0036 Maryland 21215-0036 d 2 should be filed within 72 hours all the and Mental Hygiene. 77 is marked other than "naturel; or traumatic event, the Medical Exert	To Be C		ingner	Sr.				18. Mother's N Anna	Ki	rsch	ner		
ore, of Heal	:3	19a. Informant's Name/Relationship ( Karl 0. Schlos  20a. Method of Disposition 1  Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	SS (S	late   _		ortsh sition (Nam natory or ot	ip F e of her place			e, Ma	arylaı : Location -	nd 2 City or To	1222
Baltimo permit. Pag Department Important: eny injury o		21. Signalure of Funeral Service Licer		M						_		e, Ba	1timore vland 21230
76( ite be ysicie	ical Exa	23a Part 1. Enter the disease, or com shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially 1st conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b Due to (of c.		uence of):	_						9	Approximate Interval Between Onset and Death
cords, P.O. Box 68 we requires that the death certificate been signed by the attending phy should be detached for use as it	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		th 2 ☐ Feta nt at lime of d	I death 3□	Ectopic pre Other (spe					23d. Dat Moi	e of delive	ry Day Year
ords, Paquires that en signed be detailed.		Part II. Other significant conditions of	ontributing to dea	ath bul not resi	ulting in the un	derlying ca	use give	n in Part I.		Did tobaco	M		e cause of death?
al Recc	Completed								a	Was an autopsy performed es 2 1	2   0	death?	osy findings available inpletion of cause of
On of \ ding Physi After this of	ation; To be	25. Was case referred to medical examiner?  1  Yes	28a. Dille of (Month)		ER/Outpatient 28b. Time of Injury		c. Injury Work	4 🗀 Nursing	Home 5□F	Residence	6 □Othe		)
Div	Certification;	3 Suicide 6 Could not be 4 Homicide determined	289. Place C	of Injury - At ho g, elc. (Specify	ome, farm, stre	et, factory,	office		28f. Location City or	on (Street Town, St	and Numberate)	er or Rural	Route Number,
To the Hosp within 24 hou to the Funel completely fil	Medical	29a. Certifier (Check only one) Medical Exam	ysicien: To the b niner: On the bas and manne	is of examinal	wledge, death tion and/or inv	estigation, i	п ту ор	nion, death oc	ce, and due to curred at the ti	me, date a	and place, a	and due to	the cause(s)
S S S S S S S S S S S S S S S S S S S		29b. Signature and title of certifier	ma			D	License 3	977		Ju	Date signed	2	2.006
6		30. Name and dess of person who o	n.301 k	POZZite	De		Ser	Bun	ė.n	W	211	061.	,
State Registra		31. Date filed <i>(Month, Day, Year) U</i>	32. R	Jistra S S Jna	ture	4							

			Please Type or I					-		
			For State of	Maryland /					/IIII6	17953
			Registrar		Certific	ate of L	Jeam	2. Date of Deat	eg. No. — O O	3. Time of Death
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Sca	1/2				Month 6	Day 2 Year	
	Examin		4a. Fecility Name (If not institution, give street and nun	nber)	4b. 0	City, Town, or	Location of Death		4c. County of Dea	ath /
			Howard County Gener				mbiz		11000cm	S
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. ialst 70	yrs. If U	nder 1 Year ths Days	Hours Min.	8. Date of Birth (Month, Day, Oct. 10,		rthplace (State or Foreign Jountry) ssachusetts
			Usual Residence of Decedent							10d. Inside City Limits
ırylar	show de		10a. State 10b. County	Toc. City, 18	own or Location					1 ☐ Yes 2½ No
es W	Ba-f	cto	Maryland Carroll	E	1dersbu			-	0g. Citizen of What C	
vith th	ben ben	Funeral Director	10e. Street and Number		101	. Zip Code	<b>-</b> 0.	'		ountry :
aath v	s 23g	srai	1184 Gemstone Court	dent Ever in U.S.	13 Was D		784	pecify Yes or No-	USA 14. Race - Am	erican Indian.
er de	item	, in	11. Marital Status 12. Was Dece Armed For 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes	rces?	If Yes,	specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	Rican, etc.)	Black, Wh	
urs af	or, or	by F	If Yes, Giv 3 XWidowed 4 □ Divorced Year or Da	е	1 □ Ye	s 2 XNo	Specify:		Specify:	White
at yidilid 4 14 13 2000 should be filled within 72 hours after death with tha Maryland	f health and Mental Hyglene. Item 27 is marked other than "raturel", or items 23a or 28a-1 show other treumatic event, the Medical Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	1/	6a. Decedent's	Usual Occupa	ation furing most of word )	kina	16b. Kind of Busines	s/Industry
thin 7	e. Med	npie	Elementary/Secondary (0-12) College (1	-4or 5+)						
7 Pg	ygien ner th it, the	Ço	12		Adminis	trativ		ne (First, Middle, I	Manufact	uring
D ed E	and Mental Hygiene. is marked other than eumatic svent, the Me	Be	17. Father's Name (First, Middle, Last)  Ray Clegg				Edie		vialderi Surriamo)	
blud i	d Mer narke natic	ဥ	19a. Informant's Name/Relationship (Type, Print)		19h Mailing Add	Iress (Street a			, City or Town, State,	Zip Code)
	th an					•			rg, MD 217	
ည် <u>ခ</u> ြ	Heal tem 2 other		Karen Howard Daughter 20a. Method of Disposition	20b. Place	e of Disposition etery, crematory	(Name of			20c. Location - City o	
Dallillor Dermit. Pages	Depertment of Health a Important: if item 27 is any injury or other tre once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 5 4 ☐ Donation 5 ☐ Other (Specify)	State			ry  6-9-	2006	Salem. New	Hampshire
lit i	ortar injur		21. Signature of Fogeral Service Licensee	111	22. Nam	e and Addres	s of FacilitySte	rling As	hton Schwa	b Witzke
Ď Ž	Depe Impo		(lente to	4	1630	neraı Edmon	Home of d dson Ave	catonsvi nue: Cat	lle, Inc. onsville,	MD 21228
			23a. Part1. Enter the disease, or complications that c shock, or heart failure. List only one cause on e	aused the death. [	Do not enter the	mode of dyin	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between
Ph	ysician		Immediate Cause (Final disease or condition	Conte	p	Tunca	- Vial	In	Forch	Onset and Death
	Medical		spoulting in doath)	or as a consequen	ice of):	/				7
EX	aminer		Sequentially list conditions, b							
pg	sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	or as a consequen	ice oi):					
ou, ba executad	and al-trar	xan	that initiated events c.	or as a consequen	ce of):					
-	ysician and e burial-transit	ai	d							
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ath cert	usa	M/U	23b. Was decedent pregnant	come of pregnancy irth 2 Petal de		ic pregnancy			23d. Date of d	
- e	igned by the attending phy be detached for usa as the	Physician/Media	in the past 12 months?  1 Yes 2 No 4 Pregn	ant at time of death		r (specify)			Month	Day Year
at the	d by tl etach	Phy	9 ☐ Unknown  Part II. Dther significant conditions contributing to de	anth but not requitir	as in the underhi	ing college day	on in Part I	23e Did tol	nacco use contribute	to the cause of death?
ires t	signer bed	by	Part II. Differ significant conditions contributing to de	June-	ig in the dilderly	ing cause give	on in a caren.			robably 4 Unknown
COrds, w requires t	been signature should b	etec	Coste Renal - a	11				24a. Was a	n 24h Were	autopsy findings available
The law	S C	Completed	Taspinatory 1-0,1000	1 Hype	~/cale-	1'5		autops	med? prior to death?	completion of cause of
	ficate or, pa	e Co	25. Was case referred to medical	1 John	con (	2,5045		1 ☐ Yes : th (Check only on		s 2 No
Of VICAL Physician:	is certificate ha	o Be	examiner? Hospital:	fipatient 2□ER	/Outpatient 3F	1 DOA Oth	or		ence 6 Other (Sp	ecify)
	after this funeral di	<del> </del>	27. Manner of Death 28a. Date		Bb. Time of Injury	28c. Injun Wor			ow injury occurred	
VISION Attsnding	ar death. •ctor: After th by the funeral	atio	2 Accident investigation	II, Day Toar)	М		Yes 2 □No			
VIS	recto recto by th	Certification:	3 Suicide 6 Could not be determined 28e. Place buildi	of Injury - At home ng, etc. (Specify)	e, farm, street, fa	ctory, office		28f. Location (Si City or Town	treet and Number or F n, State)	Rural Route Number,
ie ele	irs aft ref Di lled in	Cer								
Hosp	within 24 hours after death.  To the Funerel Director: Aft completely filled in by the fun	edical	29a. Certifier  (Check only one)  1 Certifying Physicien: To the back only and man							
o ths	ithin o	Me	29b. Signature and title of certifier			29c. License	e number	2	9d. Date signed (Mor	nth, Day, Year)
-	< <b>⊢</b> Ŭ		12901			D41	(120		6-2-0	26
9			30. Name and address of person who completed caus	e of death (Item 23	3a) (Type, Print)	<i>i</i> //	100			<u> </u>
l V			F Delen 10724	Ciff	e Par	Luxen	f P/cu	14, Col	Lubie	MO 21044
	Sta		31. Date filed (Month, Day, Year) 32. R	egistrar's Signature	is do	ale.	6	7		MO 21044
	Registi	rar	. [[]] V [ [] []	West Colored of						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 5 2006 **Physician** Day Year Matilda Louise Stewart 3:00 A M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Locetion of Death 4c. County of Death Examiner College Manor Baltimore County Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthdey) **Funeral** 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Vear) 1□M 2□F Months Days Hours Yrs. Director 216 05 8667 October 25 1914 Baltimore City, MD Usual Residence of Decedent filed within 72 hours aftar death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "neturel", or items 23a or 28a-f sho other traumatic event, the Medical Evaminar must be notified at Maryland Baltimore Baltimore County Director 1 ☐ Yes 2 🔯 No 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 8203 Wilson Avenue 21234 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐XNo Specify: Completed by 3 □XWidowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Baltimore Glass Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fil h and Mantal H ' is marked oth Albert Samer ٩ Marie Mever 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Itam 27 is m any Injury or other traun once. Dennis R Stewart (Son) 343 Hopkins Landing Drive Essex, Md. 21221 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State Parkwood Cem. June 10 2006 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility
Lassahn Funeral Home Inc 21. Signatifre of Funeral Service Licensee 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) SEPSIS Examiner Due to (or as a consequence of): Physician/Medical Examiner ANFECTION & INFECTED SACRAI URINARY TRACT or Attending Physician: The law requires that the daath certificate ba axecuted sete has been signad by the attanding physician and page 2 should ba detached for use as tha burial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or as a consequence of): PRESSURE ULCER Due to (or as e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dld tobacco use contribute to the ceuse of death? 2 No 1 ☐ Yea 3 Probably 4 ☐ Unknown DIABETES ģ Completed 24b. Were eutopsy findings availeble prior to completion of cause of death? 24a. Was en eutopsy performed? 2 12 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Director: After this certific I in by tha funeral director, Be 26. Place of Death (Check only one) 25. Wes case referred to medical examiner? Other: 41 Nursing Home 5 Residence 6 Other (Specify) 212 No Hospital: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manger of Death 28e. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident completaly filled in by tha 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours efter within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier-29c. License number 29d. Date signed (Month, Dey, Year) D16619 augaresoner MO 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) C. VERGARA-SOARES AVE. LUTHERVILLE. 300 W. SEMINARY MO. 21093

Registrar

State

31. Date filed (Month, Day, Year)

JUN 0

2006

32 Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

**Physician** /Medical Examiner The law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records, or Attending Physician:

ettending physicien and for use as the burial-transit signed by the et id be detached fo page 2 should peen hes certificate the funeral director, After this within 24 hours after death. filled in by To the Hospital **Ampletely** 

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

Completed by

Be

Examine

Completed by Physician/Medical

Medical Certification; To Be

**Funeral** 

Director

worde

Item 27 ie marked other than "naturel", or iteme 23a or 28a-f ebov other traumatic event, the Madical Examinar must be notified at

Department of Health a Important: if Item 27 is any injury or other tra ODCs.

should be filed within 72 hours after and Mental Hygiene.

Pages 1 end 2

Baltimore, Maryland 21215-0036

with the Maryland

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

KARA FORSYTHE 0 7 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.



Wolfe Street, Daltumore, MD 2128

29c. License number

RES-000

29d. Date signed (Month, Dey, Year)

			State of Maryland / Department of Health and M  1- State of Maryland / Department of Death	lental Hygi	_	096	1795
	Ohu		1. Decedent's Name (First, Middle, Last)	2. Date of Death	h	Vone	3. Time of Death
		sician edical		June		2006	12:55 PM
	Exa	miner	Broadmeade Cockeysville		Balti		
	Fune Direc		5. Social Security Number 213-38-5981 6. Sex 1 Months 1 M 2 NF 91 Yrs. 1 Months 1 Months 1 Min. 1 Min.	8. Date of Birth Month, Pay, Jan 17	<b>T91</b> 5	9. Birthp Mary	lace (State or Foreign
	rland	1	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
	e Man	Director	Md. Baltimore Cockeysville				1 ☐ Yes 2 <b>X</b> No
n	and 21215-0036  be filed within 72 hours after death with the Maryland that Hygiene.  and other than "natural", or flema 23a or 28a-1 show	ai Dire	106. Street and Number 10f. Zip Code 21030	10	og. Citizen of US		try?
9	6 after dea or Itema	Funeral	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes 2 ☒ No If Yes, specify:  1 □ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	Bla	ce - Americ ck, White,	etc.
2:55	21215-0036 d within 72 hours af giene. sr than "natural", or	ed by	3 Midowed 4 Divorced Year or Dates:		Special Special		
3	215. thin 72 e	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) + 24  Homemaker	ng	16b. Kind of B		lustry
1	121 iled wil tygien ther th	Con		(First Middle A	Own Ho		
	land be full b	To Be	63	Hare	naiden Surriai	пө)	
9	Maryland nd 2 should be file lith and Mental Hy 27 Is marked oth		19a. Informant's Name/Relationship (Type, Print)  Anne S. Payne/ Daughter  473 Edinburgh Ct. Seven				
12/06	Baltimore, Maryland 21215 permit. Pages 1 and 2 should be filed within 7/ Department of Health and Mental Hygiene. Importantly if lear 27 is marked other than "in		20a. Method of Disposition  20b. Place of Disposition (Name of cemeleny, cremation) or other place)  20c. Method of Disposition (Name of cemeleny, cremation) or other place)  20c. Method of Disposition (Name of cemeleny, cremation) or other place)  20c. Method of Disposition (Name of cemeleny, cremation) or other place)	ate 2	Oc. Location	City or To	wn, State
19	Baltin Sermit. P Separtme mportan	DUCE.	21. Signature of Feneral Service Licenses  22. Name and Address of Facility Une 1 1050 York Rd. Tow				
			23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.			4	Approximate
	Priysici	an :	Immediate Cause (Final disease or condition aaa.	ò			Interval Between Onset and Death
	/Medic Examin	_	resulting in death)  Due to (or as a consequence of):	<u> </u>			
		je je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jusease or injury that initiated events c.				
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	3760, ate be expected by buring	Ca	d. ===				
0.1	Box 687 eath certificate attending phy	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		024 De	An of deliver	
5	Records, P.O. Box 68 The law requires that the death certifical tens been signed by the attending phy and 2 should be detached for use as the	Physician/Medi	23b. Was decedent pregnant in the past 12 months?  1 Ves 2 No 9 Unknown			te of deliver	Day Year
K	S, P.O. es that the de		9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use con	ribute to the	e cause of death?
ARTORI	ecords, law requires t as been signed supplementations.	ed by	Cassactule lands (- Line		s 2 □ No	3 Proba	
AK	Beco e lawre has bee	. 0	Atral Abrillian	24a. Was an autopsy		prior to com	sy findings available apletion of cause of
		Cor			40	death? 1 🗌 Yes :	2 (SNO
0	- × ×	, <u>.</u>		(Check only one ne 5 ☐ Resider		er (Specify,	)
ΗY				28d. Describe hov			
To	Attender r death	Ca	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre	et and Numb	er or Rural	Route Number,
OROTH	Hospital or At Hospital or At 14 hours after of Funeral Direct			City or Town,	•		
$\bigcap$	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier fi⊠ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a (Check onty one) (Check o	and due to the cau ad at the time, dat	use(s) and ma te and place,	nner as sta and due to	ited. the cause(s)
	To the To the To the	M	29b. Signature and title of certifier 29c. License number		d. Date signe	d (Month, E	(ay, Year)
	-(-		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  (YRUS (TAMIDI M) 13801 YUK M COCKEYSU	_	6	101	00
	1/		CYRUS HAMIDI MD 13801 YOLK MI COCKEYSU	rlle, M	0 2	1030	)
	Reg	State jistrar	31. Date filed (Month, Day Year) 2006 32 Registrar's Signature	r			
	DHMH 17 Res	v 1/2001					
			ORIGINAL				

Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2005

17958

			• Registrar Continuate of Death	1	Reg. No.	
i i	Physici: /Medic		1. Decedent's Name (First, Middle, Last) Sherlyn Jean Savage	2. Date of Do Month MAY	Day Year	3. Time of Death 4:40 PM
h	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location  BALTI M	of Death	4c. County of Deal	th
	Funeral Director		2(4.54.830) 1 M 2 KF 57 Yrs. Months Days Hours	Min. 8. Date of Bi (Month, D.	9. Bin 29, Year) 5• 1949	thplace (State or Foreign buntry) MD
	ath with the Maryland 23s or 28s-f show	tor	Usual Residence of Decedent  10a. State  ND  10b. County  NA  Bal.Himore			10d. Inside City Limits 1 Set 2 □ No
	with the	i Direc	5421 Daywalt Avenue 101. Zip Code 2120)	0	10g. Citizen of What Co	ountry?
5-0036	be filed within 72 hours after des ital Hygiene. In other than "neturel", or items event, the Medical Examiner.m	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, specify Cuban, Mexical II Yes 2 No Specify Year or Dates:	rigin? (Specify Yes or Non, Puerto Rican, etc.)	o- 14. Race - Ame Black, Whit	
21215-0		Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12th grade  15. Decedent's Education (Give kind of work done during most life. DO NOT use retired)  College (1-4or 5+)  Lath grade	st of working	16b. Kind of Business Social	Security
land		To Be	01 . 0	ner's Name (First, Middle  Raqie Di	e, Maiden Sumame) (UMM)	d
Maryland	s 1 and 2 should be Health and Menta tem 27 is marked other traumatic e	_	19a. Informant's Name/Relationship ype, Print)  19b. Mailing Address (Street and Numb  19c. Mailing Address (Street and Numb  5421 Day Walt)	oer or Hural Route Numb		
Baltimore,	00-		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Sveenment Crematory	Date	20c. Location - City or Baltin	Town, State
Baltii	permit. Pag Department Important: I sny Injury o		21. Signature of Funeral Service Licensee  22. Name and Address of Fall  23. Name and Address of Fall  24. Name and Address of Fall  25. Name and Address of Fall  26. Name and Address of Fall  27. Name and Address of Fall  28. Name and Address of Fall  29. Name and Address of Fall  20. Name and Address of Fall  20. Name and Address of Fall  21. Signature of Funeral Service Licensee	The second secon		
	Physician		arrest,	Approximate Interval Between Onset and Death		
68760,	Attending Physician: The law requires that the death certificate be executed to redeath.  Sector: After this certificate has been signed by the attending physician and postor. After this rector, page 2 should be detached for use as the burial-transit.	dicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infiltated events resulting in death) Last  a. SEVERE SEPTIC SH  Due to (or as a consequence of):  FEET ULCERS INFE  Due to (or as a consequence of):  PERTHERAL VASCUL  Due to (or as a consequence of):	CTION	FASE	
O. Box 6	at the death certifii by the attending t	ysician/Medical	IFFEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown		23d. Date of de Month	livery Day Year
ls, P.0	res that I	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part END STAGE RENAL DISEASE		tobacco use contribute to	
Division of Vital Records,	The law requires that been singled bage 2 should be	Completed by Physici	DIABETES MELLITUS	24a. Was	s an 24b. Were an prior to death?	utopsy findings available completion of cause of
Vita	ysician: The lar is certificate has director, page 2	To Be C	examiner?	ce of Death   Check only	-	no fel
ion of	nding Physath. r: After this e funeral di	ation: T	27. Manner of Death  1 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 1 Light Accident investigation  M 1 Yes 2	28d. Describe	how injury occurred	iony)
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	ne Hospital 24 hours a ne Funeral fi	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, de and manner stated.	and place, and due to the ath occurred at the time	cause(s) and manner as, date and place, and dur	s stated. e to the cause(s)
	To the l	Me	29b. Signature and title of certifler RACHLIMD 29c. License number RES 0	00	29d. Date signed (Mont	/
	10		30. Name and address of person who completed cause of death (Item 23a) ype, Print) SALIM RAGHLI - GOOD SAMACITAN HOST TAL	5601 LOG	CH LAVEN CE- MD-	21239

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0 7 2006

SHERLYNJSAVAGE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle Last) **Physician** /Medical 4b. City, Town, or Location of Death Examiner nt institution, give street and number (In yrs. last birthday, 6 Sax 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year Min 1 □ M 2 💢 F Yrs. Director yari Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 'natural', or Itams 23a or 28a-f show or other traumatic event, the Medical Exemple must be putified at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ょら Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 | Yes | 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No 21215-0036 Specify: þ 3 Widowed 4 Soivorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DONOT use retired) and Mental Hygiene. /Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fit and Mental F Q 501 25 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Health Important: If Itam 27 any injury or othar tra 20b. Blace of Disposition (Name of Baltimore, Method of Disposition Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee mo 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. complications that caused the death. Do not ent Approximate Interval Between Onset and Death Immediate Cause (Final 0 **Physician** L nonths disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner A pue burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year ☐Yes 2 No 4 ☐ Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2- No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Tother (Specify) HOSPICE 1 ☐ Yes 2 ☑ No 10 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred within 24 hours after death. To tha Funaral Diractor: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 025205 MA7 30 2006 no 6601 N. CHARLES STREET and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON MD ZIZOY

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State Registrar 31. Date filed (Month, Day, Year)

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2006

gistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** VIRGINIA 6:23 PM THACKER 2006 JUNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE HARBOR HOSPITAL N/A 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 K F Director 86 Oct 24, 1919 Virginia 226-28**-**7481 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-fehov filed within 72 hours after deeth with the Maryle Hygiene Other than "naturat", or Iteme 23a or 28a-1 ehov ont, I'm Mydical Expirition must be routified a 1 ☐ Yes 2X No Maryland Anne Arundel Directo Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21225 619 Biscayne Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White δ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Colfege (1-4or 5+) Efementary/Secondary (0-12) Housewife & Mother Homemaker Ith and Mental Hygie 27 is marked other t treumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be innent of Health and Mental Innt: If Item 27 is marked o S. Turner Vera James Lee 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO BOX 1141, Victoria, Virginia Vera Tackett (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Depertment of Important: if any injury or once. Cedar Hill Cemetery 6/7/2006 Baltimore, Maryland 21. Signature of Funeral Service Licensee Kevin E Ecker McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Baltimore, Md. 21225-1856 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASPIRATION HOURS PNEUMONIA /Medical Due to (or as a consequence of): Examiner IMPAIRED SWALL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be execufed burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ ISCHEMIC Completed COLITEC 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? FIRRILLATION 24a. Was an has autopsy performed? 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 1 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) within 24 hours after death.
To the Funerel Director: After th
completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ANatural investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ahitean, m.o RES 000 JUNE 4, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RACHANA PALNITE ITE HARBOR HOSPETAL 3001 SOUTH HANDVER STREET BALTIMORE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUN 0 7 2006

06-03829 Joseph Tinkler AMENI Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	Registrar	ertificate of Death	Reg. No. 2006 1796						
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)     JOSEPH TINKLER	2. Date of i Month June 4	Day Year						
	4a. Facility Name (if not institution, give street and number) 3800 West Belevedere Apartment 1112	4b. City, Town, or Location of Death Baltimore	4c. County of Death N/A						
Funeral Director	215-52-3436 XXM 2 F -5	Mantha Days House Min	f Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign MARYLAND Country)						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  MD  10c. Street and Number  1921 SWANSEA ROAD  11. Marital Status  1 Never Married  2 Married  3 Widowed  4 Divorced of Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  1 1 TH  17. Father's Name (First, Middle, Last)  RUSSELL JOHNSON  19a. Informant's Name/Relationship (Type, Print)  GRETCHEN STARKS / SISTER  20a. Method of Disposition	ity, Town or Location ALTIMORE CITY    10f. Zip Code	10d. Inside City Limits  1 XYes 2 No  10g. Citizen of What Country?  USA  r No-  14. Race - American Indian, Black, White, etc. Specify: BLACK  16b. Kind of Business/Industry  DISABLED  dle, Maiden Surname)  IKLER  Number, City or Town, State, Zip Code)						
760, cate be executed by Medical Examiner Medical Examiner	or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence consequence).	And not enter the mode of dying, such as cardiac or respirators sclerotic Cardiovascular Disease see of):							
cords, P.O. Box 68' aw requires that the death certifi as been signed by the attending 2 should be detached for use as upleted by Physician.	230. Was decement pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions contributing to death but no Diabetes  25. Was case referred to medical examiner?	2 Fetal death 3 Ectopic pregnancy f death 5 Other (Specify)  ot resulting in the underlying cause given in Part I.  23e. E	23d. Date of delivery Month Day Year  Did tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown  Vas an judopsy performed?  Yes 2 No No 1 Yes 2 No  Residence 6 Other: Scene						
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page Medical Certification: To Be Com	27. Manner of Death  1  Natural								
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Sign								

pe or Print in Black Indelible Ink. Ensure All Copies Are Legible.
TTEM#20b. PER PH 6856 6/7/06 WS
tate of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 05, 2006 12:20 AM 4c. County of Death Frederick Samuel Thomas, Sr. June 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Harford Lorien Riverside Belcamp If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/08/1915 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number Min. Months Hours 1**X** M 2□ F 212-12-0331 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2X No Harford Fallston 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21047 1906 West Grove Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 XXYes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced WW II 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Self-Employed Construction 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ruth Linton Samuel Frederick Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) - Bel Air, Maryland 21014 803 Hayden Court Frederick S. Thomas, Jr. (son) Date 10 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gdns.06/<del>09</del>/2006 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee Con . 11750 Belair Road - Kingsville, Maryland acca 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Onknown 1 Ums 24b. Were autopsy findings available prior to completion of cause of death?

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Physician /Medical **Examiner** The lew requires that the deeth certificate be executed burial-transit nding physicien and Division of Vital Records, P.O. Box 68760, or Attending Physician: death. within 24 hours efter deat To the Funeral Director Hospital completely

for use as the page 2 should be After th filled in by

**Physician** 

/Medical

Examiner

**Funeral** 

Director

e filed within 72 hours after death with the Maryland al Hygiene.
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Department of P Important: If its any njury or of once.

Baltimore, Maryland 21215-0036

Completed by Funeral Direct

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Certification: To

Medical

Registrar

31. Date filed (Month, Day, Year) State

29a, Certifier

(Check only one)

29b. Signature and title of certifier

2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 610 32. Registrar's Signature

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1 (Scertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

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	Discusted.		Decedent's Name (First, Middle, La								2. Date of De		ay Yea		3. Time of Death
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	h		30. Name and address of person who	completed cause of	death (Item	23a) (Type	Print)						<i>y</i> .	/	,
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DHMH 17 Rev 1/2001

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ORETTA TREFFINGER

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#8 per H 0356.6/15/06 TT State of Maryland / Department of Health and Mental Hygiene State Registrar 1-Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 8/13/1931. Birthplace (State or Foreign Gountry) of Birth **Funeral** Days Hours 2 🗆 F Director Usual Residence of Decede with the Maryland 10a. State 10b. County 10c. City, Town or Location 0a. Inside City Limits Items 23a or 28a-f ehow the Medical Examiner must be notified at 1 es 2 No Directo mon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21205 83 deeth Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 3 Married Maryland 21215-0036 "naturel", or 1 ☐ Yes 2X No Specify: ģ Specity: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then ndary (0-12) College (1-4or 5+) Name (First, Middle, Last) Mother's Name (First, Mic Be Deperment of Health end Mental Important: If item 27 is marked o eny injury or other treumatic eve once. Pages 1 end 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numb or Rural Route Number, State, Zip Code) 20c. Location - City or Town, State Baltimore, . Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20b 15/00 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MISON FOR uneter 21. Signature of Funeral Service Licensee M01363 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sudden INFARCTION YOCALDIA /Medical Due to (or as a consequence of): Examiner upertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examine transit The law requires that the death certificate be executed mellitus D'abetes Due to (or as a consequence of): burial-1 been signed by the attending physicien should be detached for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 KUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an s certificate has blirector, page 2 s 2 Al No 1 Yes To the Hospital or Attending Physician: efter death.

Director: After this certific
J in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one, Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours eft To the Funeral DI completely filled in 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) and address of person BATHURE FLEDERUCK NONTH STREET MARYLand 21201 10 GREENE 32. Registrar's Signature 31. Date filed (Month, Day, State 2005

Registrar

			1 - For Amend Item 2	State of M 23a per I	larylar Dr.,G	nd / Depa 856, <b>9</b> 6	artmer Hilcan	t of H	ealth a Death	ınd M	ental Hy	giene Reg. No.	200	6	17	966
v	Physici	an	Decedent's Name (First, Middle, Last,								2. Date of De Month	ath Day	Ye	ar	3. Time o	
H	/Media	al	Edward Vernie					11149 30 200					2:15	A M		
4	Examir	er	4a. Facility Name (If not institution, give Mercy Medical Cer		)					f Death	h 4c. County of			eath		
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Maryland 21215-0036	Q & D .	To Be	Michael Vernic						Anna	M. '	Varara					
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	and 2 tealth a m 27 is		Anne Buckley /	sister		3222	Dry	Brand	ch Roa	ad; l	White H	lall,	MD 2	1161		
ore	permit. Pages 1 and Department of Healt Important: If Item 2 eny injury or other once.		20a. Method of Disposition  20b. Place of Disposition (Name of cemetary, crematory or other place)  20c. Location - City or Town, State													
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Baltimore,	Departition Depart		21. Signature of Funer I Service Licens	7					s of Facility		- Head		50 Yo			
	405 e d		Ruck Towson Funeral Home Towson, MD  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												2120	
*	Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Conset and  Terminal Aspiration  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										nterval Bet Onset and			
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	To the Hospital or At within 24 hours after or To the Funeral Direction place of completely filled in by	edicai (	29a. Certifier 1 Certifying Physical Careck only one) 1 Medical Examination	sician: To the best ner: On the basis of and manner s	of examina	owledge, death ation and/or inv	occurred restigation	at the time , in my op	e, date and inion, death	place, a	nd due to the d at the time,	cause(s) ar date and p	nd manner lace, and d	as state ue to th	ed. e cause(s	)
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			Aly ms				F	198	845			may	30,	2006	£	
			30. Name and address of person who co								-	,				
			301 St. Paul Plac	e, Balti	mor	e MD	2120	1								n n
W.	Sta Registr		31. Date filed (Month, Day, Year)	32. Regist	rar's Signa	ture										

	1 - For State Registrar	State of Maryland	Certific	ent of Health a		giene 2 () Reg. No.	06	1796					
hysician /Medical	Decedent's Name (First, Middle, La     NATHANIEL	WHITE			2. Date of De Month JUNE	Day	Year 006	3. Time of Death 9:15A M					
xaminer ineral rector	4a. Facility Name (If not institution, given 2714 CLASSEN  5. Social Security Number 6. Security Number 6. Security Number 6. Security Number 7. S	AVENUE #1	BA	City, Town, or Location of ALTIMORE Conder 1 Year   If Under 2	TTY	4c. County	N/A  9. Birthpla Counti	ace (State or Foreigr					
Mo M	Usuel Residence of Decedent  10a. State  10b. County  MD  N/A		, Town or Location BALTIM	ORE CITY	00/20	77 1920		YLAND  d. Inside City Limits  XXYes 2 □ No					
	10e. Street and Number 2714 CLASSEN	VENUE #1	10f.	Zip Code 21215		10g. Citizen of V USA		ry?					
Examinar must by Funeral	11. Marital Status  1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.s Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		ecedent of Hispanic Origi specify Cuban, Mexican, s 2 No Specify:	n? (Specify Yes or No Puerto Rican, etc.)	14. Race Blace Specify	e - America k, White, et						
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Be	17. Father's Name (First, Middle, Last, ARLEY SIMUEL	_			s Name (First, Middle, RENCE WH]		θ)						
other traumatic	19a. Informant's Name/Relationship ( ANGELA PATTON	Гурө, Print) GODDAUGHTEF	19b. Mailing Addr 3303	ess (Street and Number WINDSOR B	or Rural Route Numbe LVD., BAI	Der, City or Town, State, Zin Code, 120 LTIMORE, MD 2120							
	20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	ace of Disposition ( metery, crematory of DLAWN C	Name of prother place) EMETERY 6	/14/06	20c. Location - BALTI		m, State CO., MI					
eny injury or pace.	21. Signature of Formeral Service Licensee  22. Name and Address of Facility  HOWELL FUNERAL HOME 21  4600 LIBERTY HEIGHTS AVE., BALTIMORE  23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximation and Address of Facility  Approximation and Address of Facility  HOWELL FUNERAL HOME 21  Approximation and Address of Facility  Approximation and Address of Facility  HOWELL FUNERAL HOME 21  Approximation and Address of Facility  Approximation and Address of Facility  Approximation and Address of Facility  HOWELL FUNERAL HOME 21  Approximation and Address of Facility  Approximation and Address of Facility  HOWELL FUNERAL HOME 21  Approximation and Address of Facility  Approximation and Address of Facility  HOWELL FUNERAL HOME 21  Approximation and Address of Facility  HOWELL FUNERAL HOME 21  Approximation and Address of Facility  Approximation and Address of Facility  HOWELL FUNERAL HOME 21  Approximation and Address of Facility  HOWELL FUNERAL HOME 21  Approximation and Address of Facility  HOWELL FUNERAL HOME 21  Approximation and Address of Facility  HOWELL FUNERAL HOME 21  Approximation and Address of Facility  HOWELL FUNERAL HOME 21  Approximation and Howell Funeral												
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3	29b. Signature and title of certifier  Elect III	the		29c. License number  D51476	2	JUNE (							
M	30. Name and address of person who co	ild 4000 0	ld court	Rd, Pikes	ville, MD								
State egistrar	31. Date filed (Month, Day, Year)	32 Registrar's Signatu	re foods	,									

		1 - For State Registrar	State of Maryla		artment of H		-	2.0	106	17968
		1. Decedent's Name (First, Middle, Last)				-	2. Date of De.	Reg. No. 🚄 🔍 ath		3. Time of Death
	sician edical	THOMAS LEROY					June	Day	ob6	1.02 A.M.
	miner	4a. Facility Name (If not institution, give to BALTIMORE WASHI)	NGTON CENT		4b. City, Town, or GLEN BU		1001	4c. Count		JNDEL
Fune		Social Security Number     6. Sex	7. Age (In yi	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs		h v Yearl	9. Birthpl	ace (State or Foreign
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death with the Maryland	ģ	MD ANNE AR	UNDEL	SEVERN						1X Yes 2 □ No
h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Count	try?
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	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. V	Vas Decedent of Hi f Yes, specify Cubai	spanic Origin? (S	Specify Yes or No-	14. Rac	ce - America	
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WELLS  1215-0036  within 72 hours after death with the Marylan and. than "natural", or items 23a or 28a-1 ehow	Da Da	3 ☐ Widowed 4 ☒ Divorced  15. Decedent's Educ	Year or Dates:	16a Dogge	lent's Usual Occupa	tion			ייי	JACK
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imore, Maryle Pages 1 and 2 should ment of Heelth and Men ant: if 16me 27 ie market ury or other fraumatic		1 X Burial 2 ☐ Cremation 3 ☐ R	amount from Chat-	cemetery, cren	MEMORIA	AL PK 6		20c. Location -		vn, State
Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Heelih and Mental Hygiene. Important: if item 27 ie marked other than any nitury or other fraumatic event. Item	ponce	4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		22	. Name and Address	s of Facility HO	WELL FU	NERAL	HOME	21207
m goes	d	1/ Julyne	8. Jul	4	OOO LIBE	SRTY HE	IGHTS A	VE, B	ALTIM	IORE, MD
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Division of Vital Records, P.O. Box tor Attending Physician: The law requires that the death cer after clearly.  The transport of the certificate has been signed by the attendin in by the funeral director, page 2 should be detached for use	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, stre	et, factory, office		28f. Location (St City or Town	reet and Numbe , State)	er or Rural F	Route Number,
Divisio  To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the tu	edical Ce	29a. Certifier 1 Certifying Physi (Check only 2 Medical Examin	ician: To the best of my kn	owledge, death	occurred at the time	, date and place,	and due to the ca	iuse(s) and ma	nner as stat	ed.
To the H within 24 To the F complete	Medi		er: On the basis of examin and manner stated.	and and or inve			ied at the time, da	ate and place, a	and due to th	ne cause(s)
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n-		Commercial and the second	npleted cause of death (Ite	m 23a) (Type, R	rint)	Borr M.	5. m	21 <i>Pd</i>	10	
	State	31. Date filed (Month, Day, Year)	Registrar Sign	ature_	E, ULEN	المالات المون	- M		-1.	
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			1 - For State Registrer	State of Marylan		artment o			nd Mer		iene eg. No.	200	6 1	7969
es.	41 5		Decedent's Name (First, Middle, Las	it)						Date of Deat Month	h Day	Year		of Death
	Physicia /Medic	_	Wilton		Wa	llace			ha a	ay	30	2006	22:	15₽ <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, To	wn, or l	ocation of E	Death	_	4c. (	County of De	ath	
		и	Prince Georges	Hospital		Cheve					Pr	ince	Georg	es
	/ Funeral		5. Social Security Number 6. Se	ex 7. Age (In yrs.		If Under 1 \ Months D	ear ays	If Under 24 Hours	Min. 8.	Date of Birth (Month, Day,	YearD	30 <sup>9. B</sup>	irthplace (Stat Country)	
	Director	ģ.	215-34-7487	75	Yrs.				Se	(Month, Day, eptem	ber	14 Ma	rylan	d
	p ,		Usual Residence of Decedent  10a. State 10b. County	10c Cit	y, Town or Lo	eation							10d. Inside	City Limits
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	ith th	Dire	10e. Street and Number			10f. Zip Co	ode			1	0g. Citiz	en of What (	Country?	
	ath w	rai	1844 Addison Ro			207						SA		
	r de	Funerai	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13. \	Was Deceden If Yes, specify	t of His Cuban	panic Origin , <mark>Mexican,</mark> F	n? (Specify Puerto Rica	Yes or No- in, etc.)	1	4. Race - An Black, Wh	nerican Indian, iite, etc.	
20	or f	by Fi	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give	_	1 ☐ Yes 🐉	No	Specify:				Specify: B1	1-	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. other then "natural", or fleme 23e or 28e-f show ent, the Medical Exact are must be notified at	d D	3 ₩ Widowed 4 Divorced	Year or Dates: 51 - 5		de alle Université								
7	net olice	Completed	15. Decedent's Ed (Specify only highest gra-	de completed)	(Give	dent's Usual C kind of work of DO NOT use i	done du		of working			d of Busines	,	
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	filed within Il Hygiene.	ပိ	1 2 17. Father's Name (First, Middle, Last)		Cus	coura		18 Mother's	s Name (Fi	rst, Middle, M			/11	
Maryland	d la b	Be										Ford	1	
ž	should be and Mental marked o	10	Lloyd  19a, Informant's Name/Relationship (7)		llace	a Adduses /C	trans as	Lucy	or Dural Da	huta Alumba	Cityon			
<u>a</u>	2 6 = 6												Zip Code)	
	1 and 1ealth 9m 27		Albert Wallace  20a. Method of Disposition		13/12 lace of Dispo			n Mar	bury				rlboro or Town, State	O,MD
0	00		1 St Burial 2 Cremation 3		emetery, crer	natory or othe	r place,							
Baltimore,	permit. Pag Depertment Important: I eny injury o		4 Donation 5 Other (Specify	FIGI	yland					2006	Che	elten	nam, N	1D
Sail	epering of poor in y in poor i		21. Signature of Faveral Service Licen	1590	22	. Name and A	Address	of Facility	Adam	s Fur	nera	al Ho	me PA	
	70E = 9		July &	191								Mary.	land 2	20608
- (%)			23a. Part 1. Enter the disease, or composition of the shock, or head failure. List only	flications that caused the deat one cause on each line.	h. Do not ent	er the mode o	f dying,	, such as ca	ardiac or re	spiratory arre	est,		Approxin	Between
	Physician		Immediate Cause (Final disease or condition	T	tunio	ch (	n	1 1151	ip				Onset an	id Death
4.6.	,/Medical		resulting in death)	Due to (or as a conseq		cope	1	reco						
39	Examiner		Considerable New year distance	h										
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7	outec and ansi	Examiner	Cause (Disease or injury that initiated events	c.										
oʻ	an ar	Ě	resulting in death) Last	Due to (or as a conseq	uence of);									
760,	death certificate be executed e attending physician and of for use es the burial-transit	dicai		d										
9	iffica g ph es th	ed												
Вох	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregi	nanov				23	3d. Date of d	elivery	
	deatl	Cia	in the past 12 menths? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of d		Other (speci						Month	Day	Year
O.	at the de by the a	hys	9 Unknown	9□ Unknown										
<b>.</b>	The law requires that the ate has been signed by th page 2 should be detache	by P	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying caus	se giver	n in Part I.		23e. Did tob	acco us	e contribute	to the cause of	of death?
<u>8</u>	n sig								_	1 □ Ye	s 2	No 3□F	robably 4	Unknown
Records,	w rec	Completed								24a. Was a	n	24b. Were a	autopsy finding	os available
Re	he fav	m							_	autops perform	ned?/	prior to death?	completion o	cause of
	Physician: The this certificate har director, page		25. Was case referred to medical					00 01		1□ Yes 2		1 □ Ye	s 2 No	
<b>\rightarrow</b>	certi	Be	examiner?	Hospital: 1 Impatient 2	50/0		Other			heck only on				
Division of Vital	Phy rald	7	1 Yes 2 No		ER/Outpatien 28b. Time of			4   140131		5 Reside			ecity)	
L C	ding P. After funera	lo E	1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	М	Mork?	os 2 ∐ No			,,			
2	Attending Physician: or death. rector: After this certific by the funeral director, i	Certification:	3 Suicide 6 Could not be		ome farm str					Location (St	reet and	Number or I	Rural Route N	ımber
<u>&gt;</u>	or A after Dlrec in by	i i	4 Homicide determined	building, etc. (Specif	y)	eer, ractory, o	11100		201.	City or Town		reambor or r	10/2//10010/4	arriber,
_	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Cartifying Ph	ysician: To the best of my kno	wledge des	n occurred at	ho ti-	data c=d :	place and	due to the	NI(0=/-)	and area	ne otor	
	Hos Pun Fun tely	lica	(Check only 2 Madical Exam	ninar: On the basis of examina	tion and/or in	vestigation, in	my opi	nion, death	occurred a	it the time, da	ate and	olace, and du	is stated. ie to the cause	∋(s)
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29b. Signature and title of certifier	and manner stated.		29c 1	icense	number		10	9d. Date	signed (Mor	nth, Day, Year	}
	N T S		200 Signature and Continued			a	)=	3/1	8)			1	10	,
	10		(-)			1	/ )	01			5	130	100	
	10		30. Name and address of person who											
	100		C. Donald Geor	ge 3001 Hosp	pital	Dr Ch	eve	erly,	Mar	yland	_20	785		
	Sta Registi		C. Donald Geor	2006 Maria	. St	Sperk								

			riease	ype or Finitin				-	-	
			For	State of Maryla	•			iental Hygier	ne	17070
			For State Registrar		Ce	rtificate of	Death	Reg. f	106 UUD	1/9/0
		Ю	1. Decedent's Name (First, Middle, Last	3 4				2. Date of Death Month	ay Year	3. Time of Death
	Physici /Medic		JEREMIAH	KALIEB	WAR	<i>D</i>			7 06	1200 NOOM
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death	4	c. County of Death	1
1			SINAI HOST	ITAL		Bal	HI MOTE	Cita		
	Funeral		5. Social Security Number 6. Se	7. Age (In y	rs, last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign intry)
	Director		NIA	IM 2□F	A Yrs.	Months Days	Hours Min.	(Month, Day, Yea	96 M	(Otry)
			Usual Residence of Decedent							
	yland		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Mar Mar	ţ	MD		BAL	TIMORE	}			¥☐Yes 2☐No
	1 the	rec	10e. Street and Number			10f. Zip Code		10g. (	Citizen of What Cou	intry?
	3a or 3	Funeral Director	1209 N. 4	Jood interior	MA	7122	29	L	ISA	
	ns 2	era	11. Marital Status	12. Was Decedent Ever in		-	Hispanic Origin? (Spoan, Mexican, Puerto		14. Race - Amer	ican Indian,
40	iter of iter	표	Never Married 2 Married	Armed Forces?				Rican, etc.)	Black, White	, etc.
33	Irs a	by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		1□Yes 2DMNo	Specify:		Specify: BL	ACK
ŏ	72 hours after death with the Maryland naturel', or Items 23s or 28s-f show diseal Examinating Leundillisol at	ed	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	pation	16b.	Kind of Business/li	ndustry
15	oin 7	piet	(Specify only highest grad	e completed)	(Give	kind of work done DO NOT use retire	during most of work	ing		ŕ
12	within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)						
0	a filed within al Hygiene. I other than "		17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, Maide	en Sumame)	
an	Mental Mental arked o	Be	ELLIOH i	UARD			APRI	L HODE	EC	
2	hould d Me mark merit	2	19a. Informant's Name/Relationship (T)		10h Maili	an Address (Street		al Route Number, City		in Code)
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 is marked other than "naturel", or Items 23e or 28e-1 show other traumetic event. The Madical Examinant is inclined at		A			-			:Λ .	
	and lealth m 27			MOTHER)		1.00	looping.		DACTO,	
altimore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F		cemetery, cre	nsition (Name of matory or other pla	(Ce)	Date 20c.	Location - City or T	21229
<u>E</u>	Pag nent ent: ury c		' 4 □ Donation 5 □ Other (Specify)		altimone	Cremato	NA B L Ju	na ou Bo	Himone, I	boomlood
alt	permit. Page Department o Importent: If any injury or once.		21. Signature of Funeral Service Licens	00	2:	2. Name and Addre	ess of Facility Lou	na ou Bo udon Pank F	uneral Hor	ne
B	8 9 5 5 8				3	1620 will	kena ave	Baltimone	manula	nd assag
			23a Part1: Enter the disease, or composition of shock, or heart failure. List only o	ications that caused the de						Approximate Interval Between
		S I	Immediate Cause (Final		۸ مأ	5.5				Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a cons	ATURI	Ty				
	Examiner			Due to (or as a cons	equence on.					
ll.		<u></u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	equence of):				-	
7	ad isit	Examiner	cause. Enter Underlying							
V	and I-trar	хап	Cause (Discuss or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):				-	
760,	eath certificate be exacutad attending physician and for use as the burial-transit	E		220 (0) 20 2 00110						
87	ate thysia	dicai		đ	1.44					
89	rentificat nding phy use as th	Physician/Med	IF FEMALE: MA			11/2				
Вох	th ce tend	an/l	23b. Was decedent pregnant	3c. If yes, outcome of pred 1 Live birth 2 □ Fo		Ectopic pregnanc	·v		23d. Date of deliv	
-	0 0	sici	in the past 12 months? 1 □ Yes 2 1 No	4☐Pregnant at time of 9☐Unknown		Other (specify)	<u> </u>		Month	Day Year
P.O.	t the by th tachi	hy	9 □ Unknown	3 Olkilowii						
	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions co	ntributing to death but not i	esulting in the u	nderlying cause gr	ven in Part I.	23e. Did tobacco	use contribute to	the cause of death?
ğ	quire n sig uld b	b						1 🗆 Yes	2♥No 3□Pro	bably 4 □Unknown
Records,	> 0 0	Completed						24a. Was an	24b. Were auto	opsy findings available
Re	0 - 0	E D					-	autopsy performed?	prior to co death?	ompletion of cause of
a	icate							1 ☐ Yes 2 📜	io 1 ☐ Yes	2 No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		ott	hor	(Check only one)		
of	di S	은	TLI TES ZUMNO	Inpatient 2	☐ ER/Outpatier	II 3 DUA	4   Nursing Ho	me 5 Residence		fy)
_		o	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year,	28b. Time o Injury	Wo	rk?	28d. Describe how in	ury occurred	
Sio	Attending r death. actor: Afte	cati	2 Accident investigation			M 1 🗆	Yes 2 No			
Division	ract ract	Ě	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, sti <i>cify)</i>	eet, factory, office		<ol> <li>Location (Street : City or Town, Sta</li> </ol>	and Number or Rur. te)	al Route Number,
	tel o rs aff al Di ed ir	Certification;		li .			ļ.			
	ospi hou uner ly fill		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of my k	nowledge, deat	h occurred at the ti	me, date and place,	and due to the cause	s) and manner as	stated.
	n 24 n 24 ha F	edicai	one)	and manner stated.	mation and/or in	vestigation, in my c	opinion, death occurr	ed at the time, date a	na piace, and due t	o the cause(s)
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	×	29b. Signature and title of certifier			29c. Licens	se number	29d. D	ate signed (Month,	Day, Year)
			> ( * X6400	),		P 11.	530		5/29	106
•			30. Name and address of person who co	ompleted cause of death (I	tem 23a) (Tvne				2/01/	, - 0
	1		Tancela	L. La	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	5:	00'	tosn:1	-01	
	Sta	10	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	<u> </u>	1 3 1	P	91	
	Sta Registi		4.54.4							
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. dent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician Day Year Month 702 M Man 2006 /Medical Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 00 R 7. Age (In yrs last birthday) 5. Social Security Number **Funeral** 9. Birthplace (State or Foreign Months Days Hours 3 241-48-7258 Usual Residence of Decedent Director death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 27 is marked other than "natural", or Items 23s or 28s-f show traumatic avent, the Madical Examinar must be notified at Completed by Funeral Director 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bfack, White, etc. filed within 72 hours after 1 ☐ Yes 2 No ff Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□ Yes 25% Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within and Mental Hygiene. College (1-4or 5+) 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Ma. Be ၉ 19b. Mailing Address | Street and Numb per or Rural Route Number, City or Town, State, Zip Code, Item 27 other 20a. Method of Disposition Pages 1 5 Department of important: if it eny injury or constant. Burial 2 Cremation 3 R 3 Removal from State 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** INFORCHON a MYOCORDIAL /Medical Due to (or as a consequence of): Examiner IABETE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): bivision of Vital Records, P.O. Box 68760, Certification; To Be Completed by Physician/Medical *IF FEMALE:* 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 DEctopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗋 Yes 2 No 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Diractor: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Injury investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltonere 8. Universita

Registrar
DHMH 17 Rev 1/2001

State

NII 17 1164 1/2001

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Replacement

		4 101	epartment of Health and Certificate of Death	Mental Hygi	•
Physic		Decedent's Name (First, Middle, Last)     Grace V. Anderson		2. Date of Death Month	Day Year 3. Time of Death
/Medi Exami		4a. Facility Name (If not institution, give street and number) Kernan Hospital	4b. City, Town, or Location of Deet Baltimore, MD	h	4c. County of Deeth
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth $368-16-8048$ $1 \square$ M $2 \square$ F $85$ YI Usual Residence of Decedent	day) If Under 1 Year If Under 24 Hrs	(Month, Day,	year) 9. Birthplace (State or Foreign Couptry) 1920 MIChigan
Maryland o-f ehow	tor	10a. State 10b. County 10c. City, Town			10d. Inside City Limits 1 ☐ Yes 🎉 No
h with the 23a or 284	al Director	10e. Street and Number 7710 Harmans Road	10f. Zip Code 21076	10	g. Citizen of What Country?
72 hours after death with the Maryland natural; or Items 23a or 28e-f show dical Examinat must be routhed at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2∑ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
of 2 should be filed within 72 hours alt in and Mantal Hygiene.  27 is marked other then "natural", or traumatic event, the Modical Exert.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	ecedent's Usual Occupation Sive kind of work done during most of work fe. DO NOT use retired) Self-Employed	rking	Bb. Kind of Business/Industry
s 1 and 2 should be filed within 72 he f Health and Mental Hygiene. Item 27 is marked other than "naturalle event, the Middell	To Be Co	17. Father's Name (First, Middle, Last)  Arthur H. Northcott	18. Mother's Nar	ne (First, Middle, Ma	aiden Sumame)
			lailing Address <i>(Street and Number or Ri</i> 710 Harmans Rd. Har	ıral Route Number, (	
Page nent o ant: If ury or		1 Burial 2 Cremation 3 Removal from State  '4 Donation 5 Other (Specify)  Metro	isposition (Name of crematory or other place)  Crematory 06/		Oc. Location - City or Town, State  Catonsville, MD
permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licensee Ronald S. Warde Wirector	22. Name and Address of Facility 555 W. Baltimore St	reet, Bal	timore, MD 21201
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as	y failure	or respiratory arres	t, Approximate finterval Between Onset and Death
be executed icien and burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of)  C. Due to (or as a consequence of)	$\Lambda_{\tilde{c}v^{\tilde{c}}}$	A State of the sta	
ath certifical attending phy for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 morples? 1 □ Yes 2 □ FMO   23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetef death 4 □ Pregnant at time of death	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
uires that the de signed by the d	by	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		cco use contribute to the cause of death?
The law requir ate has been si page 2 should	completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
Physician: r this certific rral director,	lon: To Be C	25. Was case referred to medical examiner?  1	titient 3 DOA Other: 4 Nursing H	th (Check only one) ome 5 Residence 28d. Describe how	ce 6 Other (Specify)
att att	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	over MD 21076
To the Hospital or Atterwithin 24 hours after de To the Funerel Direct completely filled in by the	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, control one)  1 Medical Examiner: On the basis of examination and/of and manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occur 29c. License number	rred at the time, date	so(s) and manner as stated
FSFÖ		30. Name and address of person who completed cause of death (Item 23a) (Ty	D51850	>	6-12-06
Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature	165 Cen	nah H	ospital
Regist	ar	JUN 1 3 2006   Janes 15 )			

			1 = For State Registrar	State of Marylan			of Health and M of Death	Mental Hygie	2000	5 17973
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Alvin Augu	sta Abrams				2. Date of Death Month June 3.	Day Year 2006	3. Time of Death
	Examin		4a. Facility Name (If not institution, give s				wn, or Location of Death		4c. County of Dea	
			Charlotte Hall Vet  5. Social Security Number 6. Sex		aet hirthday)	Char	lotte Hall	9 Date of Birth	St. Ma	
	Funeral Director		231 36 7429 <sup>1</sup> x	X 2□F 73	Yrs.		Pays Hours Min.	8. Date of Birth (Month, Day, Ye July 12,	Gar) Co	thplace (State or Foreign cuntry) rginia
pac	A 11		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	ocation		<u> </u>		10d. Inside City Limits
Man	= =	ţō	Maryland Prince	George's	S	uitlan	d			1 ☐ Yes 2 ☐ No X X
4	or 28	Jirec	10e. Street and Number			10f. Zip Co	ode	10g	Citizen of What Co	ountry?
40	23a	rail	6026 Ladd Roa		0 1:0	_	746		Jnited St.	
op od	in in in in in in in in in in in in in i	Funeral Director	11. Marital Status  1 □ Never Married 2 ◯ Married	12. Was Decedent Ever in U. Armed Forces? 11/□[N/es 2 □ No 1 C		***	t of Hispanic Origin? (Sp Cuban, Mexican, Puerto v	Rican, etc.)	14. Race - Ame Black, Whit	
Glod within 70 hours after death with the Mandand	i Health and Mental Hygiene. Item 27 is marked other than "naturel", or iteme 23s or 28s-f ehow other traumatic event, the Medical Examiner must be notified at	þ	3 Widowed 4 Divorced	If Yes, Give	956 962	1□ Yes 2⊡	No Specity:		Specify: Africa:	n American
3 6	dicat	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	dent's Usual C	done during most of world	king 168	o. Kind of Business	/Industry
i i	then a	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOTUSe? ilitary	,		Nat 14 +	
ע קטריים קיינו	Hygir other ont,	Be Co	17. Father's Name (First, Middle, Last)		Net II	IIILar		e (First, Middle, Mai	<u>Military</u> den Sumame)	
9 4	Aental rked tlc ev	To B	James Abrams				Rosa	Elvira Da	vis	
o change	alth and Mental Hygiene. 27 is marked other than r traumatic event, the M	•	19a. Informant's Name/Relationship (Ty)		19b. Mailir	ng Address (S	treet and Number or Ru	ral Route Number, C	ity or Town, State, a	Zip Code)
֓֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֓֓֓֡֓֓֓֓֡֓֓֡֓֡	Health am 27 ther t		Dolores M. Abrams 20a. Method of Disposition	20b. P	lace of Dispo	sition (Name	Road, Suitla		746 Location - City or	Town State
	t: If the		Maurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	em <i>etery, cr</i> er	matory or othe	r <sub>place)</sub> June : onal Cemete:	30, 2006		
			21. Signature of Funeral Service License		22	2. Name and A	Address of Facility Le	ee Funeral	Home, In	, Virginia nc., 6633 01d
Š	9 5 8		45 400	M01464			dria Ferry D			20735
	hysician /Medical xaminer		23a, Fart 1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	e cause on each line.  OVD NA VO  Due to (or as a consequence of the c	Jence of):	ter the mode of	d'sea	or respiratory arrest,		Approximate Interval Between Onset and Death
Solo be executed	5 8 9	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last	Due to (or as a consequence of the consequence of t	Jenoe of):	rilla cer	tion & with	brain	Metas	stasis
DIVISION OF What dies Division: The law confine that the double confine	igned by the attending ph be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of do 9 Unknown	death 3	Ectopic pregr Other (specin			23d. Date of del Month	livery Day Year
r day r	been signed I should be det	þ	Part II. Other significant conditions con	tributing to death but not residue.		nderlying caus	se given in Part I.			o the cause of death?
֓֞֞֜֜֜֜֜֜֜֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֓֓֓֡֓֓֓֡֓֓֡֓֡֓֡֓֡֓֡֓֡֓	as been 2 should	Completed	Chole Cy	stitis				24a. Was an autopsy	24b. Were au	utopsy findings available completion of cause of
	cate has	Con	Colon	Cancer				performed 1 ☐ Yes	i? death?	2□ No
V ILE	certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:			Other	th (Check only one)		
5	n. After this cedific funeral director,	.T	1 ☐ Yes 2 ☑ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	28a. Date of Injury	28b. Time of		Injury at	ome 5 Residence 28d. Describe how i		cify)
	ath. vr: After ne funer	atlo	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	м	Work? 1 ☐ Yes 2 ☐ No			
	within 24 hours after death.  To the Funerel Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	reet, factory, of	ffice	28f. Location (Stree City or Town, S	t and Number or Ru tate)	ural Route Number,
i de di	n 24 hou ne Funer pletely fill	Medical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examination	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or in	h occurred at t vestigation, in	the time, date and place, my opinion, death occur	and due to the caus red at the time, date	e(s) and manner as and place, and due	s stated. to the cause(s)
-	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier	A.L.		29c. Li	icense number	29d.	Date signed (Mont	h, Day, Year)
	11		Taul	Mus	·M		14509	x (	0/5/2	2006
1	511		30. Name and address of person who co	mpleted clause of death (Item	Suite	Print)	205. Pv	ince Fi	redvic	6. MD 2067
	Sta Registr		31. Date filed (Month, Day, Year)	92. Angistrar's Signa	ture	1. 11.	) / /	.,, /		

			For State	State of	of Marylan			of He	ealth a		ental Hy	giene Reg. No.	006	17975
			Registrar  1. Decedent's Name (First, Middle, La	st)			imoure				2. Date of De	ath		3. Time of Death
	Physicia	an	Josephine	S.	Brow	m					Month 05	29	Yeer 06	10:00 A M
	_/Medic		4a. Facility Name (If not institution, given			111	4h City 3	fown or	Location o	f Death	0.5		County of Dea	
	Examin	er	6902 17th. Avenu		iliber)				ville				ince Ge	
-			5. Social Security Number 6.5		7. Age (In yrs.	last birthday)	If Under		If Under 2		8. Date of Bir			
	Funeral Director			I ☐ M 2 🔀 F	85	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 01-11	y, Year) -21	Vir	thplace (State or Foreign buntry) ginia
			Usual Residence of Decedent		0.5						01 11		, V.Z.Z	8220
	ylanc	Ī	10a. State 10b. County			y, Town or Lo								10d. Inside City Limits
	Mar-f st	ig	D.C.		W	lashing	ton							12K∑Yes 2 ☐ No
	death with the Maryland	Director	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What Co	ountry?
	th wit	aD	761 Girard Sti	eet N.V	<i>I</i> •		200	01					USA	
	dea	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.	Was Decede	ent of His	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)	)- 1·	4. Race - Ame Black, Whit	
٥	after or It		1 Never Married 2 Married	1 ☐ Yes If Yes, G	2 X No		1 ☐ Yes 2		Specify:	,	, , , , , , , , , , , , , , , , , , , ,		Specify: B1	
9500-61212	ural',	d by	3 ₩ Widowed 4 Divorced	Year or E	Dates:									
<u>7</u>	"natu	Completed	15. Decedent's E (Specify only highest gr	ducation ade co <i>mpleted)</i>		16a. Dece	dent's Usual kind of worl DO NOT us	k done di	tion u <i>ring most</i>	of worki	ng	16b. Kin	d of Business	/Industry
7	vithin ne. han	dm	Elementary/Secondary (0-12)	College (	1-4or 5+)	III e.	Cook					D.C.	Public	c Schools
Z	be filed within 72 hours after death with the Marylan Ital Hygiene. Ind other than "natural", or Items 23a or 28a-f show event. The Medical Examinating must be multified at	ပိ	17. Father's Name (First, Middle, Las	1					18 Mothe	r's Name	(First, Middle	Maiden S	Sumame)	
yland	I be f ntal H ed of	Be	Robert L. Ste								ett Bov		, a , , , , , , , , , , , , , , , , , ,	
Ĕ	hould d Me mark matic	ို	19a. Informant's Name/Relationship			19h Maili	an Address	(Street a			I Route Numb		Town State	Zin Code)
Mar	d 2 s th an th an 17 Is I		Nicole Sims/Gran		er	7	•	•			News,			Esp codo)
ص ب	1 an Heall em 2		20a. Method of Disposition			Place of Dispo cemetery, crei				-	ate		ation - City or	Town, State
פַ	ages nt of : If it		1 ⊠ Burial 2 ☐ Cremation 3 [			emetery, crei rmony				6-3-	06		dover,	
Baltimore,	it. Partmer	1	<ul><li>'4 □ Donation 5 □ Other (Special</li><li>21. Signature of Funeral Service Lice</li></ul>		па	-								
g	permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event once.		O //a	0.00							shall's			
			23a, Party. Enter the disease, or con	polications that	caused the deat						Washing		D.C	Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on	each line.	20 //00 0//			,, 000,, 00	04.4.40				Interval Between Onset and Death
	Pnysician / /Medical		disease or condition resulting in death)	W	-Stage 1		Diseas	se						
	Examiner				(or as a conseq		- n·							
		ē	Sequentially list conditions,		ycystic (or as a cons-q		Dise	ease						
/	uted I Insit	min	Cause (Disease or injury											
,	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	C. Due to	(or as a conseq	uence of):							-	
/60,	ate be executed hysician and the burial-transit	ical		_ d										
9	leath certificat attending phy I for use as th													
X Q Q	death certifica e attending ph ed for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		itcome of pregna		Ectopic pre	20222				23	3d. Date of de	livery
	0 0 0	icia	in the past 12 months? 1 □ Yes 2 □ No	4 Preg	nant at time of c		Other (spe						Month	Day Year
J.	at the de by the a tached	hys	9 🗆 Unknown	9□ Unkr	nown								-	
	res that igned I be det	by P	Part II. Other significant conditions	contributing to	death but not res	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did 1	tobacco us	e contribute to	the cause of death?
ë	w require been sig should b		Hypertensive C	ardiova	scular 1	Disease	2				1 🗆	Yes 2 🔀	No 3∏Pi	robably 4 Unknown
ecords,	The law requires that the tte has been signed by th bage 2 should be detache	Completed	Anemia of Chro	nic Dis	ease						24a. Was		24b. Were at	utopsy findings available completion of cause of
1	sician: The law certificate has b irector, page 2 s	Eo	THICHIA OF OHIO	into pro-							perfo	ormed?	death?	
Vita		a)	25. Was case referred to medical								(Check only	one)		
	Physician: r this certifical director,	To B	examiner? 1 X Yes 2 □ No	Hospital: 1	Inpatient 2	ER/Outpaties	nt 3□ DO.	A Othe	r: 4 🗌 Nu	rsing Hor	ne 5 ☐ Resi	idence 62	Other (Spe	Sister-in law home.
ז סל	ding Ph h. After th funeral		27. Manner of Death	28a. Date	of Injury oth, Day Year)	28b. Time o	f 28	Bc. Injury Work	at ?	2	28d. Describe	how injury	occurred	Taw Home.
<u>0</u>	Attending in death.	atic	1 Natural 5 Pending investigation	on		,	М		'es 2 □ i	No				
Division	tal or Attendits safter death.  al Director: A ad in by the fu	Certification:	3 Suicide 6 Could not determined	200. Flac	e of Injury - At h	ome, farm, st	reet, factory,	, office		1		Street and wn, State)	Number or R	ural Route Number,
	Ital or is afte ral Dir led in l	Cer						_						
	To the Hospital of within 24 hours at To the Funeral D completely filled in	edical	29a. Certifier 1 Certifying P	miner: On the I	pasis of examina	owledge, deat ation and/or in	h occurred a vestigation.	at the time in my op	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s) a	and manner as place, and due	s stated. e to the cause(s)
	the hin 2, the R	Med	one)	and mar	nner stated.		200	. License	number			20d Data	signed (Mont	h Day Voor)
	To Wit To	-	29b. Signatus and title of certifier		100					D C				, -u,, , cai)
			royle	26.	SIL	-, M	Dri	MI) 4	350 (	D.C.	)	06-0	T-06	
	1		30. Name and address of person who					M I	T IJC	chin	gton, ]	n C	20017	
			Prospero A. Flo  31. Date filed (Month, Day, Year)		D. IIO		um ot	. IV . I	_ wa	oull.	gron, I	<i>D</i> • C •	~UU1/	
	Sta Registr		51. Date med (Month, Day, Year)	32.	logistiai s signa									
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DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygieneo o o

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3	- 1	2	- 1	1

				Otate of IVI	arylana /	Certificate		Wichtarity	Reg. No.	Ub	1976
			1. Decedent's Name (First, Middle, Las	it)				2. Date of De	eath		3. Time of Death
	Physic /Medi		Lawrence R.	Banks,	Jr.			Month 0.5	Day 2.4	Year 06	6:40 P.M
,	Exami		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, o			y of Death	U. 70 1 • F1
	Funeral Director		Manor Care Chevy 5. Social Security Number 6. \$ 577-40-5288 1	Chase ex 7. Ag M 2□F	ge (In yrs. last b	virthday) If Under 1 \ Months D	Chevy ( Year If Under 24 Hr Pays Hours Mir	s. 8. Date of Bi	Montgo rth ay, Year) 7 27	9. Birthp	lace (State or Foreign try) ington, D.
	pu ,		Usual Residence of Decedent  10a. State 10b. County		100 City To	wn or Location					0d. Inside City Limits
	ne Maryla 8e-f shov	ctor	D.C.			ington		Ŧ			X□Yes 2□No
	ath with the 23a or 2	Funeral Director	10e. Street and Number 35 Gallatin Stre			10f. Zip Co 200	)11		10g. Citizen of USA		
Maryland 21215-0020	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "netural", or items 23a or 28e-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces? 1X Yes 2 1 If Yes, Give Year or Dates:			t of Hispanic Origin? ( Cuban, Mexican, Pue No <i>Specify:</i>	Specify Yes or Norto Rican, etc.)	5 14. Ra Bla	ce - America ck, White, of fy: Blac	etc.
5-0	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a	a. Decedent's Usual O (Give kind of work of life. DO NOT use r	ccupation lone during most of w	orking	16b. Kind of E	Business/Ind	lustry
121	within ane. Ithen "	ď	Elementary/Secondary (0-12)	College (1-4or 5	0+)				U.S. G	nvern	ment
<b>d</b> 2	filed y Hygie ont, it	ပို	12th. 17. Father's Name (First, Middle, Last)			Copier Tech		ame (First, Middle			nene
an	ld be ental kad o ic eve	To Be	LAwrence R. Bank	s, Sr.			Susan	E. Boas	man		
ary	shou and M a mar umat	-	19a. Informant's Name/Relationship (7	ype, Print)	19	b. Mailing Address (S				, State, Zip	Code)
re, M	permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other tra once.		Lawrence R. Bank 20a. Method of Disposition	-	n 6	30 Penn St of Disposition (Name e ery, crematory or other	ate, East	Strouds	burg, PA	183 - City or To	NO1 wn, State
E	Pages nent of h int: if ite		1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			opolitan C		5-31-06	Alexand	iria	VΛ
Baltimore,	permit. Departm Importa eny inju		21. Signature of Funeral Service Licen	see		22. Name and A	ddress of Facility Ma	rshall's	s Funera	1 Hom	ie
ш	80 E 9 9		I P may	hall		4217 9	th. St. N.	W. Wash	ington,	D.C.	20011
7	Physician /Medical Examiner		23a. Part 1. Inter the disease, or comp sho k, r h. In failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each line cause on each line	Lun	onot enter the mode of the consequence of):		ac or respiratory a	irrest,		Approximate Interval Between Onset and Death
x 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	,	consequence of):				-	
P.O. Box	that the death cended by the attending detached for use	Physician/	Part II. Other algnificant conditions co	ntributing to death be	ut not resulting	in the underlying caus	e given in Part I.				the cause of deeth?
σ,	that ned by e deta	by Pt						. 1	Yes 2□ No	3∐ Prob	ably 4 Unknown
of Vital Records,	e law requires that has been signed t ge 2 should be det	Completed t						24a. Was	an autopsy ormed?	ava	re autopsy findings ilable prior to npletion of cause leath?
= H	The cate h	Com						10	Yes 2 1340	1 🗆	Yes 2⊠(No
Vita	cian: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			_	eath (Check only o	one)		
on of	To the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	tion: To	27. Manner of Death  1 Natural 5 Pending	28a. Date of Inju (Month, Day	ry 28b.		Other: 4 Nursing Injury at Work?	Home 5 Resi	dence 6 □Oth how injury occur		)
Division	To the Hospital or Attending I within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ury - At home, f c. (Specify)	arm, street, factory, of		28f. Location ( City or To	Street and Numb wn, State)	ber or Rural	Route Number,
	To the Hospital within 24 hours of To the Funeral completely filled	edical C	29a. Certifier (Check only one) 1 ★ CertifyIng Phy 2 ★ Medical Exem	sicien: To the best of iner: On the basis of and manner sta	examination at	e, death occurred at the	ne time, date and plac my opinion, death occ	e, and due to the urred at the time,	cause(s) and ma date and place,	anner as sta and due to	ited. the cause(s)
	To the To the To the Comp.	W	29b. Signature and title of certifier	1		(Type, Print)	cense number 0054566		29d. Date signe 5 ) 2-6	d (Month, E 106	lay, Year)
	10		30. Name and address of person who o	ompleted cause of de	eath (Item 23a)	(Type, Print)	^				
	,		Sunither Bhogo	will, 12	20A8	art JUSS	a roed,	sceik 2	30, TOL	uson,	MD21286
	Sta Regist		31. Date filed (Month, Day, Year)  JUN 0 8 21	)06 32. Jegistra	ar's Signature	Sperker					

DHMH 16 Rev 6/95

			For State Registrar	State of Maryland	d / Department of Health Certificate of Death		2000 11311
	Physici /Medic	_	1. Decedent's Name (First, Middle, Las	VIN BUT	LER	MAY 3	Day Year 3. Time of Death 4.67 M
	Examin Funeral Director		4a. Facility Name (If not institution, give  HABOK SIDE A  5. Social Security Number  6. Se  217 - 20 - 4793  Usual Residence of Decedent	THARFORD CH	4b. City, Town, or Location  Back June 1  Ba	Of Death  NOKE  (24 Hrs. 8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23a or 28a-1 ehow eny injury or other traumatic event, it a Medical Examination and proce.	To Be Completed by Funeral Director	10a. State  10b. County  10e. Street and Number  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Ed (Specify only highest grant proceds)  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	A BA  12. Was Decedent Ever in U.S. Armed Forces?  1	If Yes, specify Cuban, Mexica  1 Yes 2 No Specify  16a. Decedent's Usual Occupation (Give kind of work done during molifie. DO NOT use retired)  DISABUED  18. Moth	rigin? (Specify Yes or No- in, Puerto Rican, etc.)  st of working  16t  UNK N  per or Rural Route Number, Co  Date  TUNE 5  LOOE  TUNE 5  LOOE  TO BE	lown, State, Zip Code)
8760,	Create be executed hysicien and physicien and physicien and street buriar-transit street buriar-transit	Ilcai Examiner	23a. Part1. Enter the disease, or come shock, or heart failure. List only disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Co al	Menal Inn	s cardiac or respiratory arrest, lent Atruny	
P.O. Box 68	thet the death certifica led by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year
of Vital Records, P.	law requires as been sign 2 should be	Completed by Ph	Part II. Other significant conditions of	ontributing to death but not resu	lting in the underlying cause given in Part	1 ☐ Yes 24a. Was an autopsy	20 use contribute to the cause of death? 2 No 3 Probably 4 Hriknown  24b. Were autopsy findings available prior to completion of cause of
tal R	Tage at a	0	25. Was case referred to medical		26. Plac	performed  1 Yes 2 2	
Division of Vi	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific.	Certification: To B	examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	100	ursing Home 5 Residence 28d. Describe how	
Di∧	pital or A burs after erel Direc filled in by		4 Homicide determined  29a. Certifier 1 Certifying Ph	building, etc. (Specify	wledge, death occurred at the time, date a	City or Town, S	State)
	the Hoe nin 24 ho the Fun npletely	Medical	(Check only 2 Medical Exan		ion and/or investigation, in my opinion, de	ath occurred at the time, date	and place, and due to the cause(s)
	To the	_	29b. Signature and title of certifier	w i	29c. License number	64	Date signed (Month, Day, Year)
DH	Sta Regist		30. Name and address of person who SHOALE A. HAS  31. Date filed (Month, Day, Year)  JUN 0 8 20	completed cause of death (Item  ALM & 2 N  32 registrar's Signat	. EUTA ST And	a 300 BAC	TIMOLEMD 21201

ORIGINAL

Joseph V Branch, Sr.

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 17978

		1- For State Registrar		Certific	ate of	Death		R	eg No	000 1101
Physici	an/	1. Decedent's Name (First, Midd Joseph V.		r				Date of Dea     Month	th Day Year	3. Time of Oeath 2118 hrs
iicai Exaiiii	illei	4a Facility Name (if not instituti			4	b. City, Town, or Lo	ocation of Deat	June 6, 20	4c. County o	of Oeath
		Sinai Hospital				Baltimore				n/a
Funeral Director		5. Social Security Number 218-03-8288		7. Age (In yrs. last bir		If Under 1 Year Months Oays	If Under 24Hr Hours Mir	,	,	9. Birthplace (State or Foreign
- Director		Usual Residence of Oecedent	1 X M 2 F		8 7 Yrs.			09-20	-1910	Country) Mary land
any		10a State 10b. County		10c. City, Town						10d Inside City Limits
daryland 28a-f show any 1 at once.	ē	Md Balt	imore	Ran	dall	stown		.,_		1 Yes 2 X No
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygener and Mental Hygener is a fired within 15 marked other than "natural", or items 23a or 28a-f she ratic event, the Medical Examiner must be notified at once	Director	10e. Street and Number	D J			10f. Zip Code 2113	3	1	0g Citizen of Wh USA	at Country?
ith the 23a o		9702 Mendoz		edent Ever in U.S	13. Was	Decedent of Hisp		pecify Yes or No		- American Indian, 8lack,
death w	Funeral		Armed Fo		If Ye	es, specify Cuban, I	Mexican, Puerte		White	rican-
after c	by F		vorced If Yes, Give Year or Dates:			Yes 2 X No			Specify	nerican
hours 'natur		<ol> <li>Decedent's Education (Specific Elementary/Secondary (0-12)</li> </ol>		4 == 5 +>	during mo	's Usual Occupationst of working life. (	OO NOT use re	tired)	16b. Kind of Bus	
5-0036 led within 72 hours at tygiene other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12)	4	I D	irec	tor of	Housin	ng-		te of
5-0036 led within Hygiene other than the Medica	ပ္ပ	17. Father's Name (First, Middle			<u> </u>	City 18				y Lung
Z1Z15-( uld be filed v Mental Hyg marked oth	o Be	Joseph L. Br 19a. Informant's Name/Relation		146	h Mailina	Address (Street		ent Je		a State 7in Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygien intention and intention or other traumatic event, the Medical Examiner or other traumatic event, the Medical Examiner	ĭ	Joseph V, Br								, Md 21133
ore, MD ss I and 2 sho of Health and If item 27 is		20a. Method of Oisposition		20b. Place	of Disposi	tion (Name of ceme	etery,	Oate	20c. Location -	City or Town, State
Baltimore, permit Pages I a Department of He Important: If it in injury or other t		1 Burial 2 Crematic			tus !	Mem. Par		12-06		us, Maryland
Baltimo permit Page Department o Important: injury or oth		21. Signature of Fundal Service		//	22. N	ame and Address	of FacilityW y	lie F/F	P.A.	of Balto. Co. town, Md 2113
	2	28a. Part I. Enter the disease, of	or complications that ca	used the death. Do n						
Physician /Medical		failure. List only one caus	e on each line	ulmonary Thror						Between Onset and Death
Examiner		Immediate Cause (Final diseas or condition resulting in death)	Oue to (or as a	consequence of).						
	ŀ	Sequentially list conditions, if any, leading to immediate		ein Thrombosis consequence of):						
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated	Subdural H	ematoma						
red l	Exal	events resulting in death) Last	Due to (or as a d.	consequence of):						
execu ian and ial - tra	ical	UNPENOED	AMENDED							
8760, C, tificate be executed ng physician and as the burial - transit	n/Medical	IF FEMALE:		outcome of pregnancy			7		23d. Date of	•
Sox 68 leath certifi e attending for use as 1	cian	23b. Was decedent pregnant in past 12 months?	LIVED	and at time of do ath	2 Fet	al death 3 L	Ectopic pregr	ancy	Month	Oay Year
Box e death or the atten ed for us	Physicia	1 Yes 2 No 9 U	9 OHKIN	wn	- [] 0					
P.O.	by P	Part II. Other significant cond				nderlying cause giv	ven in Part I.			bute to the cause of death?  Probably 4 Unknown
tal Records, P.O. B rian: The law requires that the de certificate has been signed by the ector, page 2 should be detached I	ted	Hypertensive Athero	Scierotic Cardiov	ascular Disease	=			24a Was		Vere autopsy findings available
of Vital Records,  ng Physician: The law requir  offer this certificate has been some and director, page 2 should be	Completed								rmed? d	rior to completion of cause of leath?
Re I: The lificate or, page		25. Was case referred to medic	eal I			26.Place	of Oeath (Check	1 Yes	2 No 1	Yes 2 No
Vital ysician his cert directo	o Be	examiner?  1 ✓ Yes 2 No	Hospital:	npatient 2 🗸 ER/0	Outpatient		ther -	ing Home 5	Residence 6	Other
Division of Vital Records, P.O. Box 68760, —, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death the Funeral Her Funeral After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	-	27. Manner of Oeath	28a. Oate (Month Unknow	of Injury 28b Day,Year)	. Time of I			28d. Oescribe Multiple fall	how injury occurre	ed
Sion ottendi death ctor: y the f	atio		estigation				es 2 V No	<u> </u>		DI DI - N Cit.
Division ospital or Attendir hours after death nucral Director: A y filled in by the fu	Certification:	del	ula riot be	e of Injury - At home, unknown	farm, stree	et, factory, οπισε bu	ilaing, etc.	or Town, S , unknown,	State)	er or Rural Route Number, City
Hospita 24 hours Funcral	1	4 Homicide  29a Certifler 1 Certifying	Physician: To the bes	t of my knowledge, d	eath occur	red at the time, dat	e and place, an	d due to the cau	se(s) and manner	as started.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Ex	aminer:On the basis of	of examination and/or lated	investigat	ion, in my opinion,	death occurred	at the time, date	and place, and d	ue to the cause(s)
F % F 5	ğ	29b. Signature and tille of certi	fier			29c. License				ed (Month, Day, Year)
		//	1/2			O.C.N	1.E.		June 7, 200	JO
13		30 Name and addless of person Mary G. Ripple MD.		se of death (Item 23a) Medical Examine		Penn Street,	Baltimore. I	MD 21201		
1	tate			gistrar's Signature	Loss					<del></del>
Regis			LUUD STATES	the property						

		State of Maryland / Department of Health and No. 1-State Registrar  Amend Item 2 per Dr., G856, Of 108 26 dhb eath	Mental Hygier	2000	17979
Physic /Medi		Palestine A. Brown	2. Date of Death 0		3. Time of Death
Funeral Director	ner	4a. Pacility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4co of Samaritan Hospital  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  1 M 25(F  7 Yrs.  4b. City, Town, or Location of Death  Baltimore  1 Under 1 Year   If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth	4c. County of Death  9. Birthp  County  A	lace (State or Foreig try)
ath with the Maryland 23a or 28a-f show	ector	10a. State 10b. County 10c. City, Town or Location  Baltimore			0d. Inside City Limits 1 ☑ es 2 ☐ No
15-0036 72 hours after deal "natural", or items	Completed by Funeral Director	10. Street and Number  3237 40 dale Aue  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of works)  16b. Zip Code  2/2/3  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto I Yes, specify Cuban, Mexican, Puerto I Yes 2 No Specify:  15. Decedent's Education (Give kind of work done during most of works)  16a. Decedent's Usual Occupation (Give kind of work done during most of works)  16b. Zip Code  17 Yes, specify Cuban, Mexican, Puerto I Yes, Specify Cuban, Mexican, Puerto I Yes, Specify Cuban, Mexican, Puerto I Yes, Specify Cuban, Mexican, Puerto I Yes, Specify Cuban, Mexican, Puerto I Yes, Specify Cuban, Mexican, Puerto I Yes, Specify Cuban, Mexican, Puerto I Yes, Specify Cuban, Mexican, Puerto I Yes, Specify Cuban, Mexican, Puerto I Yes, Specify Cuban, Puerto I Yes, Specify Cuban, Mexican, Puerto I Yes, Specify Cuban	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Black.	an Indian, etc.
laryland	To Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (Charles Cornish  19a. Informant's Name/Relationship (Type, Print) (Brother)  19b. Mailing Address (Street and Number or Rura	e (First, Middle, Maid Doh al Route Number, Cit	MOZN	Code)
Page:		20a. Method of Disposition  1 Burial 2 DCremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Technology  Technology  Technology  Technology	Lucy $B_{c}$ Date $S_{c}$	Location - City or To	21205 wn, State
Baltill permit. I Departm Importation		21. Signature of Funeral Service Licensee  Licensee  Licensee  Licensee  Licensee  Licensee  Licensee  Licensee  Licensee  Licensee  Licensee  Licensee  Licensee  Licensee  Licensee  Licensee  Licensee  Licensee  Licensee	Truspa 1. Bulto	L Service	1
6760, Cate be executed Examiner by physician and physician and the burial-transit the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac content shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	or to spiratory arrest,		Approximate Interval Between Onset and Death
BOX 6 death certifi	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of deliver Month	ry Day Year
	ted by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Hypertensian Diabetes	23e. Did tobacco	use contribute to the	
I Re The lay ate has	e Completed	End stage renal disease,  Per phonol vasender disease  25. Was caser ferred to medical	24a. Was an autopsy performed?	prior to com death?	sy findings available pletion of cause of 2 No
Division of Vital To the Hospital or Attanding Physician: 1 within 24 hours after death. To the Funeral Director: After this certifical completely tilled in by the funeral director, p.	Certification: To B	examiner?  1 Yes 2 X No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hon  27. Manner of Death 1 X Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be	me 5 Residence 28d. Describe how inj	and Number or Rural	
De Hospital ( n 24 hours al ne Funeral D	Medical Ce	29a. Certifier  (Chack only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 medical Examiner: Un the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cause( ed at the time, date ar	s) and manner as sta nd place, and due to t	ited. the cause(s)
vithin 2 rothe complete	Me	29b. Signature and title of certifier  29c. License number  p 1958 4	29d. D	ate signed (Month, D	-
Sta Registr		30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)  Good Saman tan Host; tal 560 Lock Raven Blud, Be  31. Date filed (Month, Day, Year)  31. Date filed (Month, Day, Year)		MD 2123	l

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 1 per doc 9856 6-8-06 vt.

State of Maryland Pepartment of Health and Mental Hygiene 2 0 0 6

1 - State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) BRANSON 2. Date of Death ALICE 3. Time of Death Physician 2:15 AM JUNE 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOSPITAL BAUTIMORE NIA BON SECOUR 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 7/5/1917 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 212 18 835 Yrs. Director 88 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d, fnside City Limits Baltimore 1 ØYes 2 ☐ No NIA Directo MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "naturel", or Items 23s or Winson Ave 2331 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Specify: þ 3 BWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry it of Health and Mental Hygiene. If Item 27 is marked other than or other treumatic event, I'm M. Elementary/Secondary (0-12) College (1-4or 5+) HOME MAKER years 12 TH GRADE POMESTIC 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Unk Pages 1 and 2 should be WILSON Harry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Branson Milton 3231 Late Ave. Annapolis, MD 21403 Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Depertment of important: if eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Cometery 6/6/06 BALTO. MD Arbutus 22. Name and Address of Facility
Youngh C. Greene Fureral Services 21. Signature of Funeral Service Licenses 515 P Batto, XXXI Pike, Baltimore, MD raugho rieno 31930 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death ATHEROSCLEROTIC COROWARY ARTERY DISEASE **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetaf death 23b. Was decedent pregnant in the past 12 months? 23d. Date of defivery 3 Ectopic pregnancy jo Month Day Year 4☐Pregnant at time of death 1 ☐ Yes > No 5 Other (specify) ate has been signed by the page 2 should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ of Vital Records, Completed 1 ☐ Yes 2 🗷 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has performed? 1☐ Yes 2 X No director Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one es 2 No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 2 ER/Outpatient DOA After the 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28c. fnjury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural death. 1 Yes 2 No 2 Accident completely filled in by the Director; 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours efter To the Funeral Direc determined 4 \ Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

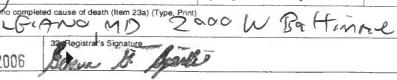
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

JUN 0 8 2006

EDWARD

31. Date filed (Month, Day, Year)



			1 – For State Registrar	State of Maryl		artmer rtificat			nd Mei		iene	06	17981
п	Physic	an	Decedent's Name (First, Middle, Las	t)					2.	Date of Deat	h Day	Year	3. Time of Death
1	/Medi		ROY ANTHONY	BAGLEY					C	6-05		1001	12:00 PM
	Examir	ner	4a. Facility Name (If not institution, give			4b. City,	Town, or	Location of	Death		4c. County		
		40	3915 BARRINGTON				MOR					NA	
•	Funeral		5. Social Security Number 6. Se	914 005	rrs. last birthday) Yrs.	Months	r 1 Year Days	If Under 24 Hours	Min.	Date of Birth (Month, Day,	Year)	9. Births	place (State or Foreign ntry)
	Director		215 60 669 Usual Residence of Decedent	40	113.				10	0.17.10	156		MD
	land •••		10a. State 10b. County	10c.	City, Town or Lo	ocation							10d. Inside City Limits
	Man,	ţō	mo NA	B	unmor	E							1 ☑Yes 2 ☐ No
	r 28s	Director	10e. Street and Number			10f. Zip	Code			10	g. Citizen of V	Vhat Cou	ntry?
	23a o	a D	3915 BARRINGTON	ROAD #5			21207	[			1.1	LSA	
	dea	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.				n? (Specify	y Yes or No- an, etc.)	14. Race	e - Americ	can Indian,
98	or It		1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		1  Yes		Specify:	dello nic	an, etc.)		k, White,	etc.
8	72 hours after death with the Maryland naturel', or Iteme 23e or 28e-f ehow disel Exeminar must be redified at	d by	3 Widowed 4 Divorced	Year or Dates:				Cpoony.			Specify	BLA	ICK
21215-0036	"nat	Completed	15. Decedent's Edi (Specify only highest grad		16a. Dece (Give	dent's Usu	al Occupa ork done d	ition u <i>ring m</i> ost o	of working	1	6b. Kind of Bu	siness/In	dustry
12	within lene. then "	Ę	Elementary/Secondary (0-12)	College (1-4or 5+)		ak D					HAULING		
d 2	Hyg ther ont.		17. Father's Name (First, Middle, Last)	NA	1200	ac o	NO YES		s Name /F		laiden Sumam		
Maryland	Mental Mental arked o	To Be	ROY LEE BAGLEY					ELIZAE		TABOR		0)	
37	2 should and Men is marke aumatic	-	19a. Informant's Name/Relationship (T)	ype, Print)	19b. Maili	ng Address					City or Town,	State Zir	(Code)
	s 1 and 2 should f Health and Men Item 27 is marke other traumatic		ANTHONY BAGLEY	(SON)	00	BARR			4 .		TO . MC		207
Je,	es 1 a of Hei f Item r othe		20a. Method of Disposition	I	p. Place of Dispo cemetery, crei	sition (Nar	me of	Hart	Date		Oc. Location -		
Ĕ			1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify,		DUDON P	-	nor prace	'	0-12.	OL P	ALTIMO	05	MO
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licens				d Addres	s of Facility	2. Ka.	il serv	TEITHO	CE,	IVO
<u>m</u>	Dep m b b b b b b b b b b b b b b b b b b		Vaughn C.	1	519	LUGHN 51 BAU	0. NA	IL DIKE	BALI	D. MD	21229		
200			23a. Part1. Entekthe disease, or comp shock, or heart failure. List only o	lications that caused the dine cause on each line.	eath. Do not ent	er the mod	le of dying	, such as ca	rdiac or re	spiratory arre	st,		Approximate Interval Between
A. Santa	Physician		Immediate Cause (Final disease or condition	Para	chapte	1 (	/\ L   C	7					Onset and Death
7	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):			- 4					7100
8	Lxammer		Sequentially list conditions,	b									
1	ed sit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):								
٧ _	and and il-tran	хап	that initiated events resulting in death) Last	c Due to (or as a cons	equence of):								
8760,	ate be executed hysicien and the burial-transit												
687	\$ 50 E	Physician/Medical		d									
Вох	seath certifica attending ph I for use as th	/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre	gnancy						22d Date	of delive	
m.	death s atte d for	cla	in the past 12 months?	1 Live birth 2 ☐ Fi 4 ☐ Pregnant at time of		Ectopic pr Other (sp	egnancy ecify)				Mon		Day Year
P.O.		hys	9 ☐ Unknown	9□ Unknown									
	The law requires that the te has been signed by th vage 2 should be detache	by P	Part II. Other significant conditions con	ntributing to death but not i	esulting in the u	ndertying c	ause givei	n in Part I.		23e. Did toba	acco use contri	bute to th	e cause of death?
ğ	w require been sig									1 XYes	2 □ No	3 🗌 Prob	abfy 4 □Unknown
ပ္ပ	hasbe hasbe je 2 sho	Completed								24a. Was an	24b. W	/ere auto	psy findings available
<u>س</u>		ρ U								autopsy perform 1 Yes 2	ed? de	rior to con eath? Yes	πpletion of cause of
/ita	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?					26. Place of		heck only one,	N .		
£	Physi this c al dire	၉	1 ☐ Yes 2 No		☐ ER/Outpatien		A Other	° 4 ☐ Nursir	ng Home	5 🗷 Residen	ce 6 Othe	r (Specify	)
ŭ	ding F	on	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		8c. Injury Work:			Describe how	intury occurre	d	
Si Si	Attending r death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	20 - 50		М		es 2 □ No					
á	l or Attendate after death Director:	Certification:	4 Homicide determined	28e. Pface of Injury - Al building, etc. (Spe	nome, tarm, str city)	eet, factory	, office		28f.	Location (Stre City or Town,	et and Numbe State)	r or Rural	l Route Number,
	spital ours ours refel filled		29a. Certifier 1 Certifying Phys	sician: To the best of my k	nowledge death	occurred	at the time	data and n	lace and	due to the			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Medical Exami	ner: On the basis of exami and manner stated.	nation and/or inv	estigation,	in my opi	nion, death o	occurred a	t the time, dat	e and place, ar	ner as sta nd due to	ated. the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier			29c	. License	number		290	d. Date signed	(Month, L	Day, Year)
			1 Zeeth C.	tend		7	000	236	57	7	612	12	1
	(0		30. Name and address of person who co	empleted cause of death (II	em 23a) (Type,			00	0 1	0	0 0	01	9
	4		1 Jos wind	101-1			(	Rut	25				
	Sta	-	31. Date filed (Month, Day, Year)	32. Agistrar's Sig	nature:	and)							
	Registr	al 💮	2018 0 0 70	UU Salahan	No NOW	-							

Be Completed by Funeral Director	1. Decedent's Name (First, Middle, Last Joyce  4a. Facility Name (If not institution, give Levindale N/H  5. Social Security Number 6. S. 213-46-3390  Usual Residence of Decedent  10a. State 10b. County Md  10e. Street and Number  607 Pennsylvania  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  (Specify only highest grate Elementary/Secondary (0-12) 12th grade	BELL e street and number)  ex	rst birthday) Yrs.  Town or Locati	Balto f Under 1 Year fonths Days	Location of Death  If Under 24 Hrs.  Hours Min.	2. Date of Death Month JUNE  8. Date of Birth (Month, Day, 7-23-1	Day You 200 4c. County of Year)	
Be Completed by Funeral Director	4a. Facility Name (If not institution, give Levindale N/H  5. Social Security Number 6. S. Social Security Number 10. State 10b. County Md  10a. State 10b. County Md  10b. Street and Number 607 Pennsylvania 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ec (Specify only highest gra	ex   7. Age (In yrs. las   57   10c. City,   Ba   12. Was Decedent Ever in U.S. Armed Forces?   1   Yes, Give Year or Dates:	rst birthday) Yrs.  Town or Locati	Balto f Under 1 Year Ionths Days ion	If Under 24 Hrs.	3. Date of Birth (Month, Day,	3 d 200 4c. County of Year) 9	Death  De
Be Completed by Funeral Director	Levindale N/H  5. Social Security Number 6. St  213-46-3390 1  Usual Residence of Decedent  10a. State 10b. County Md  10e. Street and Number 607 Pennsylvania  11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Ec (Specify only highest grant Elementary/Secondary (0-12)	7. Age (In yrs. last)  7. Age (In yrs. last)  7. Age (In yrs. last)  10c. City,  10c. City,  12. Was Decedent Ever in U.S. Armed Forces?  1  Yes, Give Year or Dates:	rst birthday) Yrs.  Town or Locati	Balto f Under 1 Year Ionths Days ion	If Under 24 Hrs.	(Month, Day,	Year) 9	e. Birthplace (State or Country) Md
Be Completed by Funeral Director	5. Social Security Number 6. S  213-46-3390  Usual Residence of Decedent  10a. State 10b. County  Md  10e. Street and Number  607 Pennsylvania  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Ec (Specify only highest grade)  Elementary/Secondary (0-12)	N/A  A Avenue Apt 1  12. Was Decedent Ever in U.S. Armed Forces? 1   Yes 2000   14   Yes 2000   15   Yes 7   16   Yes 7   17   Year or Dates:	Yrs. M Town or Locati alto	f Under 1 Year fonths Days ion 10f. Zip Code		(Month, Day,	Year)	Country) Md
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Be Completed by Funeral Director	Usual Residence of Decedent	N/A  a Avenue Apt 11  12. Was Decedent Ever in U.S. Armed Forces? 1 \( \text{Yes} \) AyNo If Yes, Give Year or Dates:	Town or Locati	10f. Zip Code		7-23-1	948	
Be Completed by	10a. State Md  10b. County Md  10e. Street and Number 607 Pennsylvania  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Ec (Specify only highest gra  Elementary/Secondary (0-12)	N/A Ba  A Avenue Apt 1.  12. Was Decedent Ever in U.S. Armed Forces?  1	alto	10f. Zip Code				10d. Inside Cit
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Be Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0·12)	Year or Dates:		Yes 2 No		1 110411, 010.)	Specify:	
Be	(Specify only highest gra							Black
Be			16a. Decedent	t's Usual Occupa d of work done d	ition <i>furing m</i> ost of work )	ing 1	6b. Kind of Busin	ness/industry Security
Be		College (1-4or 5+)		m Clerk				stration
O Be	17. Father's Name (First, Middle, Last)	N/A			18. Mother's Name	e (First, Middle, M		
	Daniel R. Bell					Coles		
2	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailing A	Address (Street a	and Number or Run		City or Town, Sta	ate, Zip Code)
	Troy York - Son		_	•	n Avenue		•	
	20a. Method of Disposition	20b. Plac	2.000	on (Name of ory or other place			0c. Location - Cit	
	1 🔀 Burial 2 ☐ Cremation 3 ☐  1 4 ☐ Donation 5 ☐ Other (Specify	Tuellioval from State		emetery	1	2006	Lansdov	van Md
	2 Signatury o Funeral Service Licen	The second secon					West	vii, riu
	/ XUMMAIN	Winte	1					21215
	23a. P. rt1. Enter the disease, or com	plications that caused the death.	Do not enter th	he mode of dying	, such as cardiac			Approximate Interval Betw
	Immediate Cause (Final							Onset and D
	resulting in death)			DISE	ASE			IYEAR
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Jer	Sequentially list conditions, if any, leading to immediate		nce of):					
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	resulting in death) Last	Due to (or as a conseque	nce of):					
		d						
Med	IF FEMALE:							
ian/	23b. Was decedent pregnant	1 ☐ Live birth 2 ☐ Fetal d	eath 3 □Ect				23d. Date of Month	,
/sic	1 ☐ Yes 2 ☑ No	4∐ Pregnant at time of dea 9□ Unknown	th 5∐Ot	ther (specify)				,
Ph		ontributing to death but not resulti	ing in the under	rhying cause give	in in Part I	23e Did toba	Icco use contribu	ite to the cause of de
by								
etec	rigirac lension,	ENDSTAGE NET	VAL D	13 CMSC.		-		
npi						autopsy	prio	re autopsy findings ar r to completion of car
S						1 Yes 2	2No 1 🗆	Yes 2 No
Be	25. Was case referred to medical examiner?	Hoepital:		Otho				
-		1 Inpatient 2 LE						Specify)
ion	1 Natural 5 Pending	(Month, Day Year)	Injury	Work	?	200. Describe 1104	v injury occurred	
ical	3 ☐ Suicide 6 ☐ Could not be	9 OS Pierrafiana Aha				28f. Location (Stre	et and Number o	or Bural Boute Numb
ertif	4 Homicide determined	building, etc. (Specify)	e, iaiiii, sticet,	, ractory, office		City or Town,	State)	* 110121 110010 110110
	(Check only 2 Medical Exam	niner: On the basis of examinatio	edge, death oc n and/or invest	curred at the tim	e, date and place, inion, death occurr	and due to the cau	use(s) and manne e and place, and	er as stated. due to the cause(s)
0	one)	and manner stated.						
Medic		2 man man				29		
Medic	( ► DX) QY∩ (\A   T \ ] · (			100	74121		JUNE 3	, " 2006
Medic		4 1 4 4 11 44	2-) (Tues Dais					
Medic	30. Name and address of person who	completed cause of death (Item 2 Chere Avenue			2400	10-1	21215	
	0 0	23a. P. f1. Enter the disease, or com s. ock, or heart failure. List only Imm. diate Cause (Final disease, or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that intitated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23a. P. t1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition refulting in death)   Immediate Cause (Final disease) or conditions refulting in death)   Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or mult) that intitated events resulting in death) Last    IF FEMALE:	23a. P. 11. Enter the disease, or complications that caused the death. Do not enter to slock, or heart failure. List only one cause of each line.  Immediate Cause (Final disease or condition refullting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ign); that initiated events resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  d.  Due to (or as a consequence of):  d.  Due to (or as a consequence of):  d.  Due to (or as a consequence of):  Due to (or as a consequence of):  d.  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  A Pregnant at time of death of the pregnant at time of the pregnant at time of the pregnant at time of death of the pregnant at time of dea	23a. P. ft. Enter the disease, or complications that gaused the death. Do not enter the mode of dying spock, or heart failure. List only one cause or each line.    Immediate Cause (Final disease or condition resulting in death)	23a. P. f1. Enter the disease, or complications triat paused the death. Do not enter the mode of dying, such as cardiac or splick, for heart failure. List only one cause greach line.    Immodiate Cause (Final disease) or condition refulling in death)	23a. P st1. Enter the disease, or complications triat daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrespinatory arres	A Sequentially list conditions grave from the fisher of the death of

				1 - State Amend Item Registrar		• <b>,</b> G85	6,062	<b>98/</b> 0	felhb	Death				U 6	1/983
		Physici	ań	1. Decedent's Name (First, Middle, L Joseph Barnett	ast)						2	Date of De	Day	Year	3. Time of Death
		/Medic Examin		4a. Facility Name (If not institution, g	ive street and number)			4b. Ci	ty, Town, o	or Location of	Death	MAY	4c Coun	y of Death	Jiwa
	1	± Adrill	Ų.	Marokin Ma	nov				JUIN	cess f	Ann.	e	So	mers	et
		Funeral			Sex 7. Age 1 23 M 2 ☐ F		st birthday	) If Und Month	der 1 Year is Days	If Under 24 Hours	Min.	. Date of Bir (Month, Da	ay, Year)	9. Birthpl Coun	lace (State or Foreign try)
		Director		265-16-4040 Usual Residence of Decedent		81	Yrs.	1			De	ec 29,	1924	AZ	
		yland		10a. State 10b. County		10c. City,	Town or L	ocation						10	Od. Inside City Limits
		e Mar	ctor	MD Wicomic	0	Sali	sbury	r							1 Yes 2X No
		vith th	Director	10e. Street and Number				10f.	Zip Code				10g. Citizen of	What Coun	try?
		death with the Maryland ms 23a or 28a-f show rmust on notified at	Funeral	907 Sapphire Co	12. Was Decedent E	ver in U.S	13	Was De		804	n? (Snecit	fy Yes or No	USA	ce - America	an Indian
	(0	be filed within 72 hours after death with the Marylan tal Hygiene. Id other than "natural", or itams 23a or 28a-f show event, the Mudical Examination must be notified at		1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🖾 N		,			dispanic Origii an, Mexican,	Puerto Ric	can, etc.)	Bia	ack, White,	
	93	within 72 hours after ene. then "natural", or its	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 LJ Yes	2 <b>⊠</b> No	Specify:			Speci	⁄y: whit	e
	5-6	natu	ete	15. Decedent's I (Specify only highest g			16a. Dece	edent's U	work done	oation during most of d)	of working		16b. Kind of I	Business/Ind	lustry
	12	withir lene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)			Build				Constr	uctio	n
0.0	Maryland 21215-0036	i and 2 should be filed w featth and Mental Hygie m 27 is marked other ti her traumatic event, ID	Be C	17. Father's Name (First, Middle, Las	t)			ur			s Name (F	First, Middle	, Maiden Suma		
10	Jar	Menta Menta	ToE							Sally	y Rae	Wate	rs		
13	Man	2 sho and Is ma		19a. Informant's Name/Relationship	(Type, Print)								er, City or Towr	, State, Zip	Code)
0		ges 1 and 2 should t of Health and Men If Item 27 Is marks or other traumatic		Amelia Barnett/s	pouse	20h Pla	907 ace of Disp			Court	Sali	- man - many -	, MD 2 20c. Location	1804	um Ctata
2	nor	Pages nent of lint: If Its	1.5	1 ☐ Burial 2 ☐ Cremation 3 4 ☒ Donation 5 ☐ Other (Spec	Removal from State	се	metery, cre	matory	r other pla	ce)	Sui		20c. Location	- City or 10	wn, state
A	altimore,	그 든 뿐 글		21. Signatury of Funeral Service Lis	insee	1/1	2	2. Name	and Addre	ss of Facility					
W.	ä	permi Depa Impo any Ir once		Jenner &	11/1	200		tate alti	, Anat more,	omy Bo MD 21	ard ( 201	655 W.	Baltin	ore S	treet
	100			23a. Part1. Enter the disease, or conshock, or heart failure. List ont	molications that caused y one cause on each lin	the death. e.	Do not er	iter the m	ode of dyir	ng, such as ca	ardiac or r	espiratory a	rrest,		Approximate Interval Between Onset and Death
20	9	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a	Asc	WD								Onset and Death
10		Examiner		1	Due to (or as a		ence of):								
Ce		200	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a										
16		ocuted nd transil	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.										
4) .	60,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as a	conseque	ence of):								
ı	68760	icate physi s the b	edical		d.										
*		n certif		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnan							23d. Da	ate of deliver	v
6	Box	ires that the death certific signed by the attending p I be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at t 9□Unknown			_lEctopic _l Other (	pregnancy s <i>pecify)</i> _	<b>′</b>					Day Year
1	P.0	d by the	Phy	9 Unknown		A m = 4 - = = - 1	dia a ia dh -		_			CO. Dili			
8	Records,	signe d be c	d by	Part II. Other significant conditions	contributing to death bu	t not resul	ung in the t	naenying	cause giv	en in Part I.					e cause of death?
×	COL	w requir been s should	lete									24a. Was			sy findings available
	Re	sician: The law certificate has b irector, page 2 s	Completed									autop perfo	rmed	prior to com death?	pletion of cause of
L	Vital	10 LT	BeC	25. Was case referred to medical examiner?						26. Place of	f Death (C	1 ☐ Yes Check only o		1 Yes 2	2 LJ NO
0	of V	Physician: r this certific ral director,	2	1 ☐ Yes 2 No	Hospital:					4 Mursi	ing Home	5 🗌 Resid	dence 6 □Ot/	ner (Specify)	
5		ding Phys n. After this funeral di	tlon:	27. Manper of Death  1 ☑Natural 5 ☐ Pending  2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) 2	28b. Time o Injury	of M	28c. Injur Wor	yat k? Yes 2 ∐No		l. Describe h	now injury occur	red	
5	Division	Atten r deat octor: by the	fica	3 Suicide 6 Could not	28e. Place of Inju	ry - At hor	ne, farm, st			103 2 110		Location (S	Street and Numi	er or Rural	Route Number.
11	Ö	s afte al Dire	Certification:	4 Homicide	building, etc.	. (Specity)						City or Tow	vn, State)		
		To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical (	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best o	examinatio	ledge, dear on and/or in	th occurre	ed at the tin	ne, date and p pinion, death	place, and	I due to the a	cause(s) and m date and place,	anner as sta	ited. the cause(s)
		ro the	Mec	29b. Signature and title of certifier	and manner stat	.00.									
				Jahr				The state of the s	D	4709	4		May 26,	2006	
20	-			30. Name and address of person who	completed cause of de	ath (Item 2	23а) (Туре,	Print)			,				12 1 501
T 340				31. Date filed (Month, Day, Year)	4 TESAN	/L	115	5	210	13/62	51-/	5.	TC1513UF	7	21004
H		Sta Registr		JUN 0 7 200	6 Alexander	J.	Good	Par o							1) 2/80/L

			1_ For State	State of Maryl	land / Depa	artment of H	lealth and N	•	_	7984
			Registrar		Cei	tificate of	Death		g. No.	
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Larry Ways	ne Cook, Sr.	•			2. Date of Death Month June 7	Day Year	3. Time of Death  2:17 a M
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death		4c. County of Dea	
			Carroll Hospi	tal Center		West	minster		Carrol	.1
	Funeral Director		5. Social Security Number 6. Sex 217–46–2289	M 2□F 7. Age (In	yrs. last birthday) B Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 27,	1948 Ma	rthplace (State or Foreign country) cryland
P.	>15.00		Usual Residence of Decedent  10a. State 10b. County	100	: City, Town or Lo					Land to the control of
aryla	ohov H	_	,	100	•					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
M	-88-T	acto	Md. Carroll		Finks					
with ti	0 or 2	吉	10e. Street and Number	0:		10f. Zip Code	0	10	Og. Citizen of What C	•
athy	23g	E C	131 Lassi			2104			U.S.A.	
U KIKIO-0000 filed within 72 hours after death with the Maryland	f Health and Mental Hygiene. Item 27 is marked other than "natural", or Iteme 23s or 28e-f ehow other traumatic event, the Medical Examinar must be routilled at	by Funeral Director	11. Marital Status  1 □ Never Married 2(1 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No ff Yes, Give Year or Dates:		Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 1 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	Decify Yes or No- Pican, etc.)	14. Race - Am Black, Whi Specify: W	ite, etc.
3 8	tural E E		15. Decedent's Educ		163 Deces	ient's Usual Occup	ation		16b. Kind of Business	
<b>15.13</b>	han "na a Mudic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done o DO NOT use retired	during most of world i)	king		•
y pe	ygier thert	S	11		1.6	awn Maint			Landsca	ping
	and Mental Hygiene. Is marked other than aumatic event, tra Ma	Be	17. Father's Name (First, Middle, Last)					ie (First, Middle, N		
should be	Men arke	은	Raymond A. (					len E.P.E		
2 sh	and is m		19a. Informant's Name/Relationship (Ty)						City or Town, State,	
and and	of Health item 27 i rother tra		Mary Sue Cook .						irg, Md. 2	
es 1	T ite		20a. Method of Disposition 1 Burial 2 Ocremation 3 R	amoval from State		sition (Name of natory or other plac	(9)		20c. Location - City of	
Pag	ant:		4 □Donation 5 □ Other (Specify)		Metro	Cremator	y June 8	3, 2006 E	Baltimore,	Md.
Dallillor Dermit. Pages	Department of Himportant: If Ite only injury or ot once.		21. Signature of Furieral Service License	on Al	22	. Name and Addres E•khardt	Funeral	Chapel,	P.A.	
Pi	nysician Medical		23a. Part : Enter the disease, or complishock, or hear failure. List only or Immediate Cause I final disease or condition resulting in death)	cations that caused the de cause on each line.	Ke	IIIOO Re	1 sterstor g, such as cardiac	or respiratory arre	wings Mil st,	nproximate Interval Belween Onset and Death
be executed	ysicien and burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor						
To the Hospital or Attending Physicien: The law requires that the death certificate	been signed by the attending phys should be detached for use as the	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. ff yes, outcome of pre 1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown	Fetaf death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
, L	ned b a deta	y PI	Part II. Other significant conditions con	tributing to death but not	t resulting in the ur	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
w requires t	n sign	d b	Smoking	( )				1 <b>X</b> Ye	s 2 □ No 3 □ P	robably 4 Unknown
The law rec	ate has bee page 2 shor	omplete	large alc	shot (	gnsur	notion		24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
clen:	rtific.	BeC	25. Was case referred to medical	The two stores			26. Place of Dear	th (Check only one	/	
ysic	is ce direc	ToE	examiner? 1 ☐ Yes 2 💆 No	ospitaf: 1 🗌 Inpatient	ER/Outpatien	t 3 DOA Oth	er: 4 Nursing Ho	ome 5 Resider	nce 6 Other (Spe	ecify)
2 g	er th		27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c. Injun Worl		28d. Describe hov		
<u>5</u>	ath. r: Aft e fun	ate	1 Natural 5 Pending 2 Accident investigation	(North, Day 16a	u/ Injuly		Yes 2 □No			
DIVISION al or Attending	within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp.	At home, farm, streecify)	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or R State)	tural Route Number,
Hospit	Funeri Funeri	edical (	(Check only 2 Medical Examin	ician: To the best of my	knowledge, death	occurred at the tin	ne, date and place, pinion, death occur	and due to the car red at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
the	hin 2 the mplet	Med	one)	and manner stated.						
To	To Cor	-	29b. Signature and title of certifier	O 1.1.4		29c. Licenso	/ 1/ >	29	ld. Date signed (Mon	or, Day, Year)
			LADOCA	a In	$\mathcal{D}$	しわら	6116		6- +- C	16
	1		30. Name and address of person who co D. Allixander Rach	CA 4/23/1	loc thun	rede Tro	ul Hum	pstead	2, MOa	1074
	Sta Registr		31. Date filed (Month, Day, Year)	2. Registrar's 3	ionature	le le	1.0037	7	1001	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 19b per fh 8856 6-8-06 vt.

State of Maryland? Department of Health and Mental Hygiene?

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Voor **Physician** CORNETTE 1900 PM JOHANNA JUNE 2006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) CENTER 4c. County of Death **Examiner** BALTIMORF JOHNS HOPKINS BAYVIEW MEDICAL If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 08-01-1947 Birthplace (State or Foreign Country) **Funeral** 1 M 2/CXF Director 218-48-4979 58 MD Usual Residence of Decedent the Maryland 10a State 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Iteme 23a or 28a-1 ehow eny injury or other traumetic event, the Medical Exeminating the modified at 10b. County 10d. Inside City Limits 1X Yes 2 No Director Baltimore Baltimore 10e. Street and Number 2 Liberty Parkway 10f. Zip Code 10g. Citizen of What Country? 21222 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② Who If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Marned White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Doris Marie Frank Eugene Gunther unknown 19b. Mailing Addr**Rulaski** Number or Rural Route Number, City or Town, State, Zip Code) 21162 11345 <del>Puliski</del> Highway lot 17-20 White Marsh MD 19a, Informant's Name/Relationship (Type, Print) Kitten Winger/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory Date 20a. Method of Disposition 20c. Location - City or Town, State 06-08-2006 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility CAFA Stephen D. Lohrmann PA 8717 Green Pastures Dr. Towson, MD 21286 M00984 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) RENAL FAILURE **Physician** IWEEK /Medical Due to (or as a consequence of): Examiner I WEEK SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed the burial-transit Due to (or as a consequence of): P.O. Box 68760. physicien Physician/Medical for use es IF FEMALE: 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 24 No Month 4 Pregnant at time of death 5 ☐ Other (specify) tha detached ۾ cete has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Knknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physicien: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitaf: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 2 ER/Outpatient 3□ DOA 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending after death. Director: Af investigation 1 Tyes 2 No 2 ☐ Accident illed in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours after To the Funeral Dire To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29c. License number 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) JUNE 3, 2006 RES-000 30. Name and address of person why completed cause of death (ftem 23a) (Type, Print) EASTERN AVE NUE BALTIMORE, MD 21274 4940 JACOB

DHMH 17 Rev 1/2001

State Registrar SNETTA

31. Date filed (Month, Day, Year)

DR.

**ORIGINAL** 

32. Registrar's Signature

			For State Registrar		Sta	ite of M	larylar		artment <i>rtificate</i>				lental Hy	giene Reg. No.	4 U U	6	17986
	Dharaia		1. Decedent's Nam	e (First, Middl	e, Last)								2. Date of De				3. Time of Death
	Physici /Medio				A1	phons	0.	Craft					5 5	Day 28		<sub>06</sub>	1:30 P. M
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	Funeral		5. Social Security N	lumber	6. Sex		ge (In yrs.	last birthday)	If Under	1 Year Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da	th V Year)	9.	Birthp	lace (State or Foreign
	Director		213-30-7		1 <b>X</b> □M 2		73	Yrs.		50,0				6-19	33	000.	Va
	and w		Usual Residence of 10a. State	Decedent 10b. County			10c Cit	ty, Town or Lo	cation							1	Od, Inside City Limits
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21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is markad othar then "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	1 Never Marr		ied 1 [	ned Forces Yes 2 Yes, Give ar or Dates:	? <b>[</b> No		f Yes, speci	fy Cuba	Specify:	, Puerto I	Rican, etc.)		Black, \ Specify:	White,	
5-0	2 should be filed within 72 hours and Mental Hygiene. is markad other then "naturel"; aumatic event, the Modical Exa	Completed	(Spec	15. Deceden	t's Education	oleted)		16a. Deced	ient's Usual kind of work	l Occupa	ition	of worki	na	16b. Kir	nd of Busin	ess/Ind	dustry
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yla	ould Men narka	2	William								Mart						
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	ned I	by P	Part II. Other signif	icant condition	ns contributir	ng to death t	but not res	ulting in the ur	derlying car	use give	n in Part I.		23e. Did to	obacco us	se contribut	te to the	e cause of death?
ıd	w require been sig should b												101	res 2□	] No 3 [	] Proba	ably 4 Whiknown
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ita	Phyaician: Th this certificate ral director, pag	Bec	25. Was case refer examiner?	red to medical						_ 8	26. Place	of Death	Check onl o				
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	fter fter		27. Manner of Death	h 5 🗆 Pendin		Month, Da	ay Year)	28b. Time of Injury	28	c. Injury Work	at ?	2	8d. Describe h	now injury	occurred		
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Division	or Attenuation deat Diractor: in by the	Certification:	3 Suicide 4 Homicide	determ		Place of In building, e	jury - At ho tc. <i>(Specif</i> )	ome, farm, stre y)	et, factory,	office		2	8f. Location (S City or Tox		Number o	r Rurai	Route Number,
	To the Hospital or Attendi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fu		29a. Certifier	12 Certifyin	g Physicien:	To the best	of my kno	wledge, death	occurred at	t the time	e, date and	place, a	nd due to the	cause(s) a	and manne	r as sta	ited.
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DHMH 17 Rev 1/2001

Craft, Alphanso 5/28/06 13p.m.

				State of Maryland / Department of Health and M  1- State Registrar Certificate of Death		giene ()	06	17987
		Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	th Day	Year	3. Time of Death
3		/Media	cal	Raymond Walter Carter  4a. Facility Name (If not institution, gigg street and number) 4bpCity, Town, or Location of Death,	June	4c. County	2006	12:03 AM
		Examir	ier	Sinai Hospital of Battinove. Baltimore Citi	1	4c. County	oi Death	
		Funeral			8. Date of Birth	Year	9. Birthpla	ace (State or Foreign
	п	Director			8. Date of Birth (Month, Pay 5-14-	1934	Count	Md Md
		and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10	d. Inside City Limits
		Maryl f sho	tor	Md N/A Balto				1 X Yes 2 □ No
9		with the Maryland a or 28a-f show Le redified at	irec	10e. Street and Number 10f. Zip Code	1	10g. Citizen of	What Count	ry?
aste		23a c	Funeral Director	3917 Annellen Road 21215		U S	A	
63		er dez	nuei	11. Marital Status  12. Was Decedent Ever in U.S. Amed Forces?  13. Was Oecedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Rad Blad	e - America ck, White, e	
	36	irs aft	by F	1		Specif	,: B1a	ck
3	5-0036	72 hour natural'	ted	15. Decedent's Education 16a, Decedent's Usual Occupation		16b. Kind of B	usiness/Indi	ustry
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00	121	T C =	S	12th grade N/A Foreman  17. Father's Name (First, Middle, Last)  18. Mother's Name	/First Middle	Admini		10n
Raymond	Maryland 21	a la la se	To Be Completed by	Walter Earl Carter Olivia H		Walderr Surrian	16)	
50	ary	shound M	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura.		r, City or Town,	State, Zip (	Code)
4	Σ	T 4 6 5		Kelly Curry - Daughter 2319 Bluegrass Heigh	ts Ct	Balto,	Md 21	237
3	ore	of of		1 X Burial 2 Cremation 3 Demoval from State cemetery, crematory or other place)		20c. Location -		
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Knowin	Bal	permit. Departr Importa		Manada Mariana				
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	Box 6	or Attending Physician: The law requires that the death certific liter death. Director: After this certificate has been signed by the attending plin by the funeral director, page 2 should be detached for use as in by the funeral director.	lan/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Dai	e of delivery	/ Day Year
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	σ,	s that the ned by a detact		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	pacco use cont	ribute to the	cause of death?
	rds	w requires been sign should be	ed b	Diabetes	1 □ Y€	es 2□No	3 Probal	oly 4 Unknown
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	ion	nding Ph ath. r: After th e funeral	atior	27. Manner of Death  1 ☑ Assural 5 □ Pending (Month, Day Year)  2 □ Accident investigation  28a. Date of Injury 28b. Time of 28c. Injury at Work?  2 □ Accident investigation  M   1 □ Yes 2 □ No		,,		
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		To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by i	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place, and place are considered.  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place are considered.	nd due to the ca d at the time, da	ause(s) and ma ate and place, a	nner as stat and due to t	ed. he cause(s)
		To the within To the comp	ž	29b. Signature and title of certifier  29c. License number	1	9d. Date signed	-	
		11		Nikhil Agarwal, MD RES-000	10	lune:	2, 2	006
		10 x,	1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NIKHIL Agarand, MD Sinai Hospital A	Bal	Tune -	0	il di
		Sta Registr		31. Date filed (Month, Day, Year)  JUN 0 8 2006  32. Regultrar's Signature				

		1- State RegistrAmend Item	State of Mary 26 Per Verb	-		Death	Reg. N	C 0 0 0	1/988
Physic		1. Decedent's Name (First, Middle, La Faith	Hope	Ι	Davis		2. Date of Death Month D	ау 2006	3. Time of Death 2:40p M
/Med Exami		4a. Facility Name (If not institution, gived 4718 Hellwig F	e street and number)		4b. City, Town, or Baltim			c. County of Death	
Funera Director	_	215-60-4647	ex 7. Age (In	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea 12-23-5	r) Cour	place (State or Foreign htry) Md.
yland how		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Le	ocation			1	10d. Inside City Limits
8e-f	Director	Md. NA		Balt	imore				1 ∑Yes 2 □ No
death with the Maryland me 23a or 28e-f ehow routl be notified at	al Dire	10e. Street and Number 4718 Hellwig Ro	ad		10f. Zip Code 21206	6	10g. C	itizen of What Cour USA	ntry?
ja 2 2	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Vidowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 27 No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ▼No	spanic Origin? (Spec n, Mexican, Puerto R Specify:	ofy Yes or No- lican, etc.)	14. Race - Americ Black, White, Specify: Bla	etc.
Z 1 Z 1 S-UU36 d within 72 hours af giene. or then "naturel", or the Medical Exem	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occupa kind of work done di DO NOT use retired)	tion uring most of workin	g 16b.	Kind of Business/In	dustry
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and Z dbe filed ental Hygic ced other	Be	17. Father's Name (First, Middle, Last,	_			18. Mother's Name	(First, Middle, Maide	n Sumame)	
Men Men atte	J.	Robert		Daniels		Peggy		Jackso	
Mar d2sh d2sh thand t7tem treum		19a. Informant's Name/Relationship (		1	ing Address (Street as		0.5		Code)
C = (4 F		Camille Davis 20a. Method of Disposition	Daughter	Ob. Place of Dispo	8 Hellwig	Da		21206 Location - City or To	own. State
<b>Baitimore,</b> Dermit. Pages 1 al  Department of Hea  Important: if item  In jury or othe  Diny in jury or othe		1		king Me	matory or other place m. Pk.	6-7-0		ndallstov	
Departition Departition of the contract of the		21. Signature of Funeral Service Licer	Warren	)	<ol><li>Name and Address</li></ol>		Baltimor		21202
a dusa o		23a. Part1. Enter the disease, or com			March F.H.			. North A	Approximate
Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. A COULC.  Due to (or as a co	20 Ima	_		^	046	Interval Between Onset and Death
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the death certy the attending	ompleted by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 manths? 1 ☐ Yes 2 1 M No 9 ☐ Unknown	23c. If yes, outcome of p 1 Live birth 2 4 Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
dS, Puires that isigned bid be detailed	d by PI	Part II. Other significant conditions of	contributing to death but no	ot resulting in the u	underlying cause give	n in Part I.		use contribute to the	ne cause of death?
VICAL RECOYDS, sician: The law requires t certificate has been signe irector, page 2 should be o	mplete	3 MORAID	OBESITA				24a. Was an autopsy performed?	24b. Were auto prior to cor death?	psy findings available mpletion of cause of
9 4	ပို	25. Was case referred to medical				26. Place of Death	1 Yes 2 N	o 1 Tes	2 No
r VITA yeician: yeician: is certific director,	0 8	examiner?	Hospital: 1  Inpatient	2LFER/Outpatie	Other	c	e 5XXResidence	6 □Other (Specifi	ivl
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VISION OT VITA Attending Physician: r death. ector: After this certific by the funeral director.	atlo	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	1	ar) Injury		es 2 □No			
2 5 g 5 E	Certification:	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injury building, etc. (S	At home, farm, st pecify)	reet, factory, office	28	Bf. Location (Street a City or Town, Sta	and Number or Rura (e)	il Route Number,
To the Hospital or within 24 hours effe To the Funerel Dir completely filled in	Medical C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	ysician: To the best of m niner: On the basis of exa and manner stated.	y knowledge, deat imination and/or in	th occurred at the time ivestigation, in my opi	e, date and place, ar inion, death occurred	nd due to the cause( d at the time, date ar	s) and manner as sind place, and due to	tated. the cause(s)
To the within 2 To the complet	W	29b. Signature and title of certifier	m.	0 -	29c. License	8120	Ju.	ate signed (Month,	<u></u>
7		30. Name and address of person who	ANAT 51-1	1	Print) Let RAU	ien hu	DAC CO	J. MD	21239
S Regis	tate trar	31. Date filed (Month, Day, Year) 8 2008		Signature			,	•	
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		_	1 - For State Registrar	State of Ma	aryland / L	epa <i>Cen</i>	rtment tificate	of He	ealth and leath	Mental H	lygier Reg. 1	La U U	6	17989
	Physici /Medi		1. Decedent's Name (First, Middle, La Lanora Virginia							2. Date of Month		) 5 2ŏ	<b>5</b> 6	3. Time of Death 12:45а м
	Examir		4a. Facility Name (If not institution, giv Stella Maris	e street and number)	_			imoni	ocation of De	ath	4	c. County of C		<u> </u>
	Funeral Director		5. Social Security Number 220-14-4489 6. S	ex 7. Age □ M 2 1 F	(In yrs. last birth	hday) rs.	If Under	1 Year Days	If Under 24 H Hours M	rs. 8. Date of I	Birth Yar	9.	Birthpli Count	ace (State or Foreign (TV) MD
	Maryland	ctor	Usual Residence of Decedent  10a. State 10b. County MD Balti	more	10c. City, Town		ation Mills						10	od. Inside City Limits 1 □ Yes 2 ื No
	th with the 23a or 28	Funeral Director	10e. Street and Number 4813 Deer park Rd	•			10f. Zip (	Code 2	21117		10g. (	Citizen of Wha US	Count	ry?
980	iges 1 end 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.  If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show or other traumatic event, the Medical Examinar must be inclified at	2	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			/as Decede Yes, speci		panic Origin? Mexican, Pu Specify:	(Specify Yes or learn Rican, etc.)	No-	14. Race - A Black, V Specify:		tc.
Maryland 21215-0036	1 within 72 he piene. Piene. I than "natu	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0·12)	ducation de completed) College (1-49r 5- 1	16a. l		ent's Usual ind of work ONOT use Beaut:		on ring most of w	vorking		Kind of Busine		,
land ?	uld be filed Aental Hygi rked other tic event, I	To Be C	17. Father's Name (First, Middle, Last) John Holthaus					11		<sub>ame (First, Midd</sub> La (unkn	le, Maide			57
	end 2 should be faith and Mental n 27 is marked er traumatic ev		19a. Informant's Name/Relationship ( John Doyle/son	Type, Print)	19b. 48	Mailing 813	Address (	Street and Park	Rd. C	Rural Route Nurr Wings M	iber, City	or Town, State	e, <i>Zip (</i>	Code)
Baltimore,	it. Partimer ritant		20a. Method of Disposition  1 Burial 2 X Cremation 3 4 Donation 5 Other (Specification)	1)		, crema eake	e Crer	ner place) nator	-	Date -06 <b>-</b> 2006	В	Location - City $ellocation$	le,	MD
Bal	Depa Impo eny ir		21. Signature of Funeral Service Licer  23a. Part 1. Enter the disease, or com- shock or head failure 1 ist only.	lu—	M009 56	22 (	Name and	Steph Green	of Facility ien D. i Pasti	Lohrman res Dr.	n_PA Tow	son MD	212	286
68760,	Physician be executed attending physician and tor use as the burial-transit	edicai Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. DEMENTI  Due to (or as a  b. Due to (or as a  c.	ð.	f): f):								nterval Between Onset and Death
P.O. Box 6	thet the death certifi ed by the attending i detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death		Ectopic preg Other (spec					23d. Date of Month		/ ay Year
Ś	w requires that been signed by should be deta		Part II. Other significant conditions of	ontributing to death but	t not resulting in t	the und	lerlying cau	use given i	in Part I.					cause of death?
al Reco	hysician: The law n his certificate hes be I director, page 2 sh	Completed									opsy formed?	prior t death	o comp	y findings available pletion of cause of
Division of Vital Record	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death cert of the safe death cert of the Februard Directors. After this certificate hes been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Certification; To Be	27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Yea <i>r)</i> Inj	me of ury	М	Other: C. Injury at Work? 1  Yes	4 Nursing	Home 5 Res 28d. Describe	sidence		oecify)	HOSPICE
<u>&gt;</u>	Hospital or At thours after d Funerel Direct tely filled in by		4 Homicide determined	building, etc.	(Specify)					City or To	own, Stat	•		
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier (Check only one)  29b. Signature and title of certifier	rsician: To the best of iner: On the basis of e and manner state	examination and/	death o	stigation, ir	the time, on my opinion	on, death occ	e, and due to the curred at the time	, date an	d place, and d	ue to th	ne cause(s)
}	6 3 5 8		•	1					372.	5	290. D8	ate signed (Mo	110	/
	Sta Registr		DR. TARTO MAHMOO  31. Date filed (Month, Day, Year)  JUN 0 8 2006	D 2300 DU	TLANEY V. s Signature .	ALL	EY RD	. T	IMONIU	M, MD 21	093			

JUNE 5, 2006 12:45 a.m.

LENORA DOYLE

		1 - For State Registrar	State of Ma		rtificate of		Mental Hy	rgiene 006	17990
Physic /Med		1. Decedent's Name (First, Middle,	DOY /	le			2. Date of De Month	Day Year	3. Time of Death
Exam		4a. Facility Name (If not institution, g	give street and number)		4b. City, Town, o	Location of Dea		4c. County of Death	1
		MILLENNIUM N	ursing Hon	NE	ELLICOTT	CITY		HOWARD	
Funera			4 1 1 4 6 1 5	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		rth 9. Birth	nplace (State or Foreign untry) VA
Directo		231.12.6600	11814 201	No. Yrs.			03.19.	19.21	VA
and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
lanyia eho	ក		1	BALTIMORI					1 <b>₹</b> Yes 2 □ No
he N 28a-f	Director	MD N	A	BHLITTIUKI				10. 0:: (1150	
with t	급		STREET		10f. Zip Code			10g. Citizen of What Cou	untry?
21215-0036  within 72 hours after death with the Maryland jiene. ir than "naturel", or Items 23a or 28a-f ehow the Medical Examinar must be notified at	Funeral	225 N. CULVER	12. Was Decedent Ex	vor in II C 13	21229 Was Danadest of H	issania Origina /	Spooifu Voo or No	LSA 14. Race - Amer	ioge ledice
iter d	Ë	11. Marital Status 1 □ Never Married 2/ Married	Armed Forces?	ver in 0.3.	Was Decedent of H If Yes, specify Cuba	ın, Mexican, Pue	rto Rican, etc.)	Black, White	
nrs af	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🕱 No	Specify:		Specify: R11	ACK
21215-0036 ad within 72 hours aft glene. ier than "naturel", or t, the Medical Exami		15. Decedent's		16a. Dece	dent's Usual Occup	ation		16b. Kind of Business/li	
15 min 72	Completed	(Specify only highest ( Elementary/Secondary (0-12)	grade completed)	(Give	kind of work done of DO NOT use retired	during most of wi	orking		
2121 Jiene. r than "	E	10 TH GRADE	College (1-4or 5+	UPHOI	LSTERY			FEDERAL G	OVT
illed other	a)	17. Father's Name (First, Middle, La				18. Mother's Na	ame (First, Middle	, Maiden Sumame) WW	K
- 0 50	To B	AMOS DOYLE				MILLIE			
aryla should lind Men s marke	-	19a. Informant's Name/Relationship	p (Type, Print)	19b. Maili	ng Address (Street	and Number or F	Rural Route Numb	er, City or Town, State, Zi	ip Code)
and 2: salth ar n 27 is		BERNICE DOYLE	(WIFE)	225	N. CULLIER	. 81., 1	BALTO. A	ND 21229	
es 1 a of Hear fitem r otha		20a. Method of Disposition	_	20b. Place of Dispo cemetery, crei			Date	20c. Location - City or T	own, State
Pages nent of int: If it		1  Burial 2  Cremation 3  '4  Donation 5  Other (Spe		GARRISON		,	12.06	OWINGS MI	aM Pu
<b>₩</b> 1 8 8 8 9 1		21. Signature of Funeral Service Lic		22	2. Name and Addres	s of Facility			·
Demi		Danon C	$\Lambda$	VA	NUGHN C. 51 BALTO.	GREENE	FUNERAL	SERVICE D. MO 2122	a
		23a. Part 1. Enter de disease, or co	omplications that caused t	he death. Do not ent	ter the mode of dyin	g, such as cardia	ac or respiratory a	rrest,	Approximate
Physician		shock, or heart failure. List on Immediate Cause (Final		SCLEROT	TO CER	FROM	1 Decul 1	e Docon	Interval Between Onset and Death
/Medica		disease or condition resulting in death)		SCHEROI	ic cen	LPNev	THOUNT	R DISEA	Z~
Examine				consequence of .					
			Due to (or as a	consequence of):					
4	e .	Sequentially list conditions, if any, leading to immediate	b	consequence of):					
uted d ansit	mlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.	b Due to (or as a						
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# % B		that initiated events	b	consequence of):					
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6/2/06 @ 11:05pm

ECK, CATHERING

#### 06-03787 Please Type or Print in Black Indelible Ink UNK UNK Andre State of Maryland / Department of Health and Mental Hygiene Felder 1. For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death June 3, 2006 ANDRE A. FELDER Medical Examiner 0230 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 916 Marcy Avenue Oxon Hill Prince George's 5. Social Security Number If Under 1 Year If Under 24Hrs. Age (In yrs. last birthday 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** 578-11-9811 Months Days Hours Director 1 X M 2 22 Yrs July 18, 1984 Country) Usual Residence of Decedent 'nί 10a State 10c. City, Town or Location 10d Inside City Limits D.C. Washington 1 X Yes 2 No 28a-f show ages 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mernal Hygene . If Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 20002 14 Channing Street, N. E. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 2 X No Yes 4 Divorced If Yes, Give Year 3 Widowed 1 Yes 2 X No specify **Black** Specify ģ 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 12th Carpenter Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel L. Felder, Sr. Nancy M. Edwards 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) B Nancy M. Felder/Mother 14 Channing Street, N.E., Washington, DC 20002 Baltimore, I permit. Pages I and Department of Heall Important: If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Harmony Memorial Park 6/12/06 Landover, Maryland Donation 5 Other Specify. 22. Name and Address of Facility Frazier's Funeral Home, Inc. Signature of Funeral Service Licenses 21. 389 Rhode Island Avenue, N.W., Wash. eshaur Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and /Medical a, Shotgun Wound of Head and Gunshot Wound of Torso Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last executed physician and the burial - trans Physician/Medical UNPENDED AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Year attending 2 Day past 12 months? Pregnant at time of death 5 Other (Specify 1 Yes 2 No 9 Unknown Unknown ned by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, P.O. 23e Did tobacco use contribute to the cause of death? þ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed After this certificate has been a funeral director, page 2 should 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? page ✓ Yes 2 ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Other<sub>4</sub> Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 🗸 Yes 27 Manner of Death 28a Date of Injury FOUND: Day, Year) 28c Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury Certification: Subject shot n 24 hours after deaun he Funeral Director: A FOUND: Natural 1 1 Yes 2 ✔ No 5 Pending Jun 3, 2006 0218 hrs 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined (Specify) Parking Lot 4 V Homicide 916 Marcy Ave, Oxon Hill, MD 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical

To the Hospital or Attending Physician: the I o

> Assistant Medical Examiner Laron Locke MD. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) UN 0 8 2006 strar's Signature State Registrar

30. Name and address of person who completed cause of death (Item 23a)

and title of certifie

and manner stated

one)

29b. Sig

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe

O.C.M.E.

29d. Date signed (Month, Day, Year)

June 3, 2006

			For State Registrar		State	of Maryla		artmen			and M	lental Hyg	iene 0	06	17993
	* * *		1. Decedent's Name (	First, Middle, L	ast)							2. Date of Dear	th		3. Time of Death
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	and the		932 Andre		1			_G1en	Bur	nie			Anne	Arun	de1
6-	Funeral		5. Social Security Num		Sex 1 ☐ M 2 🖾 F	7. Age (In yr. 86	s. last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,		9. Birthp	lace (State or Foreign
	➢ Director -	Ž I	216-18-6	7704		00	Yrs.					Sept.19	,1919	MD	
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	r 288	Director	10e. Street and Numb	er				101. Zip	Code			1	0g. Citizen of V	What Cour	itry?
	h witi		932 Andrew	s Road				2	1061				U.S.	٨	
	deat	Funeral	11. Marital Status		12. Was Dec	edent Ever in		Vas Deced	lent of His	spanic Ori	gin? (Sp	ecify Yes or No-	14. Rac	e - Americ	
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21215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23s or 28s-f show he Madical Examinar must be notified at	Completed	1! (Specify	5. Decedent's E only highest gi	ducation ade completed)		16a. Deced (Give	kind of wor	k done di	urina most	t of work	ng	16b. Kind of Bu	usiness/Ind	lustry
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an	id be ental ked o	To Be	Milton Je	rome Ha	TVAV									,	
Maryland	shound M	-	19a. Informant's Name		-	son	/ 19b. Mailin	g Address	(Street a			abeth W:		State, Zip	Code)
Ž	alth a		Mr. Willia	m R. Ga	rdner,							Burnie			,
Je,	of He item		20a. Method of Dispos	sition		20b.	Place of Dispos	sition (Nam	ne of				20c. Location ·		wn, State
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Depertment of Health and Mental Hygiene. Important: if item 27 ie marked other then "natural", or iteme 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at once.		21. Signature of	ni dervice Lice	nsee		22	Name and	d Address	of Facility	y Si	ngleton	Funera	1 Hon	ie. PA
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П		9	23a. Parti. Enter the shock, or heart for	disease, or con ailure. List only	plications that or one cause on o	caused the dea	ath. De ot ente	er the mode	of dying	, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between
6-	Physician		Immediate Cause (Fir disease or condition	nal	2		Folgo	win	u	9					Onset and Death
	/Medical Examiner		resulting in death)		Due to	(or as a conse									
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V_	xecul and al-trar	xan	that initiated events resulting in death) Las		c. Due to	(or as a conse	quence of):		32.80		ee 105.1				
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Вох	eath certific ettending p for use as f	2	IF FEMALE: 23b. Was decedent pr	regnant	23c. If yes, ou								23d. Date	e of delive	v
	death e ette	Cla	in the past 12 mg	onths?	4☐Pregr	oirth 2 ☐ Fet nant at time of		Ectopic pre Other (spe					Mor		Day Year
0	thet the de led by the detached	hys	9 🗆 Unknown		9□ Unkn	own									
	signed be del	by Physician/Me	Part II. Other significa	nt conditions	contributing to d	eath but not re	sulting in the un	derlying ca	iuse giver	n in Part I.		23e. Did tob	acco use contri	ibute to the	e cause of death?
ord	w require been si should l											1 ☐ Ye	s 2 🗆 No	3 🗌 Proba	ibly 4 Unknown
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2	tending Ph leath. tor: After th	<u>o</u>		5 Pending		of Injury th, Day Year)	28b. Time of Injury		3c. Injury a Work?			28d. Describe hor	w injury occurre	ed	
Division of	Attending Physician: r death. actor: Atter this certific by the funeral director.	cat	2 Accident 3 Suicide	investigatio 6 ☐ Could not b		of Injune At 1	nome form atte	M		es 2 N		206 /			
<u>S</u>	for At after d Direct I in by	ertification;	4 Homicide	determine	buildi	ing, etc. (Spec	nome, farm, stre ify)	et, factory,	OTTICE		4	28f. Location (Str. City or Town,	State)	er or Hurai	Houte Number,
	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	O.	29a. Certifier 1	*Certifying PI	nysician: To the	best of my kn	owledge, death	occurred a	it the time	date and	Inlace a	nd due to the ca	use(s) and mas	anor an etc	tod
	Ho 124 h	edical	one)	Medicai Exa	illiter: On the b	asis of examin ner stated.	ation and/or invi	estigation,	in my opii	nion, death	h occurre	d at the time, da	te and place, a	nd due to	the cause(s)
	withir To th comp	M	29b. Signature and title	e of certifier	0	•		290.	License	number		p 29	d. Date signed	(Month, D	Pay, Year)
			Ser.	ne		رى	n		04	68	57		6/6	100	)
	10	-	30. Name and address	of person who	completed caus	e of death (Ite	m 22a) ( yps. P	rint)			(	× -	W/V/	()	an Rosnia
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] [ 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year ALBERTUS 8R 2006 GIBSON JUNE /Medical 4a. Facility Name (If not institution, give street and number) Ab. Sity. Town, or Location of Death Examiner 4c. County of Death 405P ASNRS NA 130 If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 12M 2 F Vrs 18 Director RA8.40.4303 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or iteme 23a or 28a-f ehov tre Medical Examiner must be notified at Director 1 RYes 2 □ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3655 GELSTON DRIVE 21229 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 62 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after of Hygiene. I hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed by Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION 814 GRADE LABORER NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peges 1 and 2 should be filt thent of Heelth and Mentel Hy tent: if Item 27 is marked oth jury or other traumatic event Be HENRY GIBSON ELLA CANTY ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (MIFE) 3655 GELSTON DR. SARAH MAE GIBSON BALTO - MO 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Pege Department of Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 06.08.06 OWINGS MILLETMD 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE
5151 BAUTO. NATU PIKE, BAUTO. MO 21229 21. Sign ture of Funeral Service Licensee Vaughn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician My conclu disease or condition resulting in death) LWWS /Medical Due to (or as a consequence of): **Examiner** Theres cless he Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner use as the burial-transit ren fensin that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other/significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ page 2 should be 2 No 3 Probably 4 ☐Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 1 No 1 Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death | Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient Certification: To 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funerel Direc 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) france Baltonire, Maryland ( MW) 900 Caron

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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ORIGINAL

32. Registrar's Signature

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			1 - For State Registrar	State of Marylar	Certificate of			2006	17995
	30	- '4	Decedent's Name (First, Middle, L.	ast)	00.00.0000		Reg. I	NDL U U U	3. Time of Death
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	Exami		4a. Facility Name (If not institution, g.	ive street and number)	4b. City, Town, o	or Location of Death		4c. County of Death	1
			BonSecours	Hospital	Ba	Himore		NA	
	Funeral		5. Social Security Number 6. 251-14-1835	Sex 7. Age (In yrs.	/ Ast birthday) If Under 1 Year Months Days	If Under 24 Hrs. 1 Hours Min.	8. Date of Birth (Month, Day, Yea	ar) 9. Birth	place (State or Foreign
	Director		Usual Residence of Decedent		Trs.		4-23-191	19 Sou	TH CAROLINA
~	yland		10a. State 10b. County	10c. Ci	ty, Town or Location				10d. Inside City Limits
10	Mar B-f st	Ş	MARYLAND	V/A	BA	LTIHORE	CITY		1X Yes 2 □ No
5	0036 hours after death with the Maryland ural; or Items 23a or 28a-f show at Examinar must be multilied at	Director	10e. Street and Number		# 10f. Zip Code	27.710.0		Citizen of What Cou	intry?
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1	er de	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?		Hispanic Origin? (Spec Jan, Mexican, Puerto Ri	ify Yes or No- lican, etc.)	14. Race - Ameri Black, White,	can Indian,
(	36 rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📆 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ₺No	Specify:		Specify: 12	001
0	21215-0036 de within 72 hours at giene. er than "natural", or than "than "natural", or the Madical Exam		15. Decedent's F	ducation	16a. Decedent's Usual Occup	pation	16h	Kind of Business/Ir	ACK
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	ore, M		20a. Method of Disposition	DAS (NET HEW)	Place of Disposition (Name of	JERS HVE	E, DALT	THORE MIL Location - by or To	0.21201
	Baltimore, permit. Pages 1a Department of Her mportant: If Item any Injury or other ance.		1 Burial 2 Cremation 3 (	Removal from State	emetery, crematory or other place	ce)	200.		1 0000
	Baltimo		21. Signature of Funeral Service Lice	1	22. Name and Addre	an of Camilla.	The state of the s		N, MARYLAND
	Depariment of the police of th		Wietrich	N. Willia	MO JOSEPI	J. FULTON	WHUK.	FUNERA	L HOME
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the deat	n. Do not enter the mode of dyin	ng, such as cardiac or i	respiratory arrest,	177410, 19	Approximate
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1.	₩ ₩ ₩	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	1	1			01
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	N cert	/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal				23d. Date of delive	erv
	G G G G G G G G G G G G G G G G G G G	SICIS	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of de				Month	Day Year
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	LS, res th	þ	Part II. Other significant conditions	contributing to death but not resu	Ilting in the underlying cause give	en in Part I.		use contribute to th	
	Division of Vital Records, for Attending Physician: The law requires the after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be contact.	Completed		ES MEL			1 ☐ Yes 2	2 No 3 Prob	pably 4 Dunknown
	Aec le law has l	I du	1797E	RTENTION			24a. Was an autopsy	24b. Were autor	psy findings available mpletion of cause of
	n: Th		END	STAGE 18	ZENAZ DI	SEASE	performed? 1 ☐ Yes 2 ☐ No	o 1 Yes	2 🗆 No
	of Vital Re Physician: The la r this certificate had	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital:	SDIO Othe	26. Place of Death (C			
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	ivision relations in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factory, office	28f	f. Location (Street ar City or Town, State	nd Number or Rura	l Route Number,
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	Division of Vital Records, P.O. Box 68 To the Hospital or Attanding Physician: The law requires that the death certifical within 24 hours after death.  within 24 hours after death.  completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Pt (Check only 2 Medical Exam	nysician: To the best of my knowniner: On the basis of examinat and manner stated	vledge, death occurred at the timion and/or investigation, in my or	ne, date and place, and	due to the cause(s	and manner as st	ated.
	thin 2 the on the omple	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License				
	F 3 F 8			SON WI			1	ate signed (Month, L	
	5		30. Name and address of person who	completed cause of death (Item	23a) (Type, Print) 47	23500	J2	NE O	6 2006
			30. Name and address of person who	. PATE2	14D. 2000	W 13ALT	OST. B	ALTO M	D, 21223
	Sta Registr		31. Date filed (Month, Day, Year)	32. and sistrar's Signat	H Angella				
	a (=[011211	(-)	וו ע ח ואווו	11115 1 FT AR A	TO A SHIP SHOULD AND A SHIP SHOULD BE SHOULD B				1

	1 - State Registrar C6	partment of Health and Menta ertificate of Death	1 Hygiene 006 17996
Physician /Medical			o of Death  11
Examiner	4a. Facility Name (If not institution, give street and number)  Doctors Community Hospital	4b. City, Town, or Location of Death Lanham	4c. County of Death Prince Georges
Funeral Director	5. Social Security Number 251-22-5433  G. Sex 1 M 2 F 7. Age (In yrs. last birthda, 1 M 2 F 83  Yrs.	// If Under 1 Year If Under 24 Hrs. 8. Date (Months Days Hours Min. 01	9. Birthplace (State or Foreign Country)  22 23 Edgefield, S.C.
death with the Maryland ms 23e or 28e-f show trivial be natified at erral Director	10a. State 10b. County 10c. City, Town or		10d. Inside City Limits 13€ Yes 2 ☐ No
th with the Mar 23a or 28a-f si Int be notified	10e. Street and Number 721 Carrington Place	10f. Zip Code 20743	10g. Citizen of What Country? USA
036 urs after and the contraction of the contractio	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e	s or No- ltc.)  14. Race - American Indian, Black, White, etc.  Specify: Black
21215-0 ed within 72 ho system. her than 'natura t, the Modical I	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 8th  16a. Dec (Giv iife.)  College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) nstruction	16b. Kind of Business/Industry  George Hyman
Viand be file Mental Hy with other atto event	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Caren Hamil	·
Mar. Mar. and 2 sho eath and n 27 is m	Dorothy Hamilton/Wife 721	ing Address (Street and Number or Rural Route Carrington P1. Seat P1	
Baltimore, Maperal Paltimore, Maperal Pages 1 and 2 s Department of Health at Important: If them 27 is any injury or other traugue.	4 Donation 5 Other (Specify) Fort Li		20c. Location - City or Town, State  Brentwood, MD.
Ball Ball Permit Depart Import any in	D. P. Maushall 4:	2. Name and Address of FacilityMarshal. 217 9th. St. N.W. Washi	ington, D.C. 20011
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed by hours attending Physician and Funeral Director: After this certificate has been signed by the attending physician and Funeral Director: After this certificate has been signed by the attending physician and be perfectly filled in by the funeral director, page 2 should be detached for use as the burial-transit and proposed in the certification; To Be Completed by Physician/Medical Examiner	23a. Party Enter the disease, or complications that caused the death. Do not expression on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		Interval Between Onset and Death
, P.O. Box 6876 that the death certificate be led by the attending physicis detached for use as the bu y Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
rds, P quires that in signed b	Part If. Other significent conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e	Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Michown
Division of Vital Records, for Attending Physician: The faw requires that after death.  Interpret After this certificate has been signed in by the funeral director, page 2 should be entification: To Be Completed by	THROMBOCYTOP		Was an autopsy autopsy performed?  Yes 2 □ 10 1 □ Yes 2 □ No
Vital F sicien: The certificate riector, pag	25. Was case referred to medical examiner?	26. Place of Death (Check	
ion of National Physical Physical Control of March 1 of the Control of March 1 of the Control of	1 Yes 2 To To To Platient 2 ER/Outpatie  27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	11 3 DOA 4 Nursing Home 5	Residence 6 Other (Specify) cribe how injury occurred
Division c spital or Attending P ours after death. filled in by the funeric it Certification;	3   Suicide 6   Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		tion (Street and Number or Rural Route Number, or Town, State)
e pla	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, deal (Check only one) Certifying Physicien: To the best of my knowledge, deal (Check only one) and manner stated.	ivestigation, in my opinion, death occurred at the	to the cause(s) and manner as stated.  time, date and place, and due to the cause(s)
To To To To To To To To To To To To To T	29b. Signature and title of certifler  Luce MD	29c. License number  D 0058 290	29d. Date signed (Month, Day, Year)
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type S OR ESHKUMAR MUTTATIT \$ 203 31. Date filed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's Sign file		1340-17541 CLE, My 20141

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>006</u> **Physician** Year Helmut Hammen June 3:11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5690 French Avenue Sykesville Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 XM 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 123-32-4995 Director 70 SEP 15, 1935 Germany Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. \*ehow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ehov traumatic event, if a Missical Exacts at must be notified at 1 Yes 2 No Directo Sykesville Maryland Carroll 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5690 French Avenue 21784 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give 1050 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. t Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Year or Dates: 1959-63 Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Wholesale Sales Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill timent of Health and Mental Hitem 27 is marked other. Be 2 Heinrich Hammen Hildegard Goebel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5690 French Avenue Frances C. Hammen/Wife Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of h
Important: If Ite
any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 6/5/06 Baltimore, MD

22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licenses Edward A Gregorchik 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final IVER Physician CANCER disease or condition resulting in death) 2 months /Medical Due to (or as a consequence of): Examiner 6 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) ned by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be d þ CANCER LUNG 2 No 1 Yes 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? cate has certificate 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation Injury after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funeral C To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ATTENDING D21155 PHYSICIAN June 5, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARTHUR L. RUDO, MD 904 WASHINGTON RD WESTMUSTER, MD 21157 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 8 2006 Registrar

06-03814 Please Type or Print in Black Indelible Ink Phillip Robert Harich, Jr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1009 hrs Medical Examiner Philip Robert Harich Jr. June 4, 2006 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 446 Knottwood Court Arnold Anne Arundel 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign District Of Country) Columbia 5. Social Security Number If Under 1 Year If Under 24Hrs. 6 Sex 7. Age (In yrs last birthday) **Funeral** Days Hours Director 50 216-70-4922 1 X M 2 Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City. Town or Location 1 Yes 2 X No 28a-f show Maryland Anne Arundel Arnold death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21012 446 Knottwood Court **USA** Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc Never Married 2 X Married 2 X No Yes 9 White Yes 2 X No specify Divorced If Yes, Give Year Specify: à 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Pages 1 and 2 should be filed within 72 b traumatic event, the Medical and Mental Hygiene MD 21215-0036 Trucking Truck Driver 12 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) Philip R. Harich Sr. Bertha Poole Be 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ nt of Health and it: If item 27 is other traumat 446 Knottwood Court Arnold, Maryland 21012 Roxy Anne Harich, Wife 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Burial 2 XCremation 3 Removal from State 06/06/06 Baltimore, Maryland Metro Crematory Inc. Donation 5 Other Specify Balti permit <sup>22</sup> Name and Address of Facility
Cremation Society Of Maryland Inc.
299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service License Thomas Gregor( 23a Part I. Enter the disease, or complications that caused the dea th. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical a Contact Gunshot Wound of Head Death Immediate Cause (Final disease €xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of). events resulting in death) Last and Physician/Medical g physician a s the burial -UNPENDED AMENDED Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 🗸 Yes To the Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medical Be Other 4 DOA Nursing Home 5 Residence 6 Other: Scene Inpatient 2 ER/Outpatient 3 1 🗸 Yes ٩ Manner of Death 28a. Date of Injury 28b Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Jun 4, 2006 Subject shot self 1000 hrs Natural Yes 2 V No Pending Director: Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 446 Knottwood Court, Arnold, MD within 24 hours a

To the Finteral I determined (Specify) residence Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b Signature and title of certifier 29d Date signed (Month, Day, Year) O.C.M.E. June 5, 2006 C Name and address of person who completed cause of death (Item 23a)

Registrar

**OCME 2006** 

State

Patricia Aronica-Pollak MD.

2006

31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

strar's Signatu

06-03734 Please Type or Print in Black Indelible Ink Stannetta Harris State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ June 1, 2006 Medical Examiner Stannetta L. Harris 0834 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death c. County of Death 6143 Marquette Road Apartment # J **Baltimore Baltimore County** 5 Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 6. Sex Age (In vrs. last birthday) Months Days Hours Director 26 4-7-1980 Country) Md 2 X F M 220-94-4609 Usual Residence of Decedent 10a State any Oc. City, Town or Location 10d Inside City Limits or 28a-f show 1XX Yes 2 No Balto Md N/A Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 6143 Marquette Road Apt J 21206 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married White, etc. Yes Yes 2X No specify. Widowed Divorced If Yes. Give Year Specify Black 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Starbucks 12th grade 2 years Sales Associate/Cashier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stanley Harris Donna Singletary 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) timore, MD Stanley Harris - Father 6204 Birchwood Avenue Balto, Md 21214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c Location - City or Town, State permit. Pages 1 Department of H Important: If i Burial 2 X Cremation 3 crematory or other place) Removal from State Metro Crematory Donation 5 Other Specify: 6/7/2006 Catonsville, Md or 22. Name and Address of Facility Signature of Funeral Service Licen in e March F/H West R (Mil 4300 Wabash Avenue DAM Balto, Md 21215 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Approximate Interval Between Onset and /Medical Death a Positional Asphyxia complicating Intracranial Hemorrhage Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed and Physician/Medical UNPENDED attending physician or use as the burial -AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 Pregnant at time of death 5 Other (Specify) Yes 2 No 9 ✓ Unknown Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Obesity, Cardiomegaly 1 Yes 2 No 3 Probably 4 V Unknown Completed this certificate has been s 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 🗸 Yes No To the Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene ဥ 1 V Yes After 28a. Date of Injury FOUND: Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Asphyxiation due to body position following 1 Natural **FOUND** Yes 2 V No 24 hours after death Pending To the Funeral Director: Jun 1, 2006 0820 hrs intracranial bleed 2 🗸 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide Town, State) determined (Specify) Multi-Family Apt. 6143 Marquette Road Apartment J. Baltimore, M. 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E June 2, 2006 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner

31 Date filed (Month, Day, Year, State 0 Registrar

32. Redistrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Alberta Hunter Jun 5, 2006 12:25 a /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore MCHS- Roland Park N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 🔀 F 243-40-4267 Yrs. Director 78 No. Carolina Nov 20, 1927 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Exer ther must be notified at Director Maryland N/A Baltimore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4717 Wrenwood Avenue 21212 Items 23a Funeral U.S.A Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Yes 2 ⅓No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 ☐ No þ Specify: Specify: Black 3 ¥Widowed 4 ☐ Divorced "natural" Completed other than "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **Grocery Store** Owner 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Menta! ! Joseph Stevenson Roland Bynum ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l Charles Boyd 60 Turner Place - Apt 1V Brooklyn, New York 11218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 06/10/06 Baltimore, Maryland Arbutus Memorial Park 21. Signature of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Small Cell Carcinoma of liver and bone /Medical Due to (or as a consequence of): Examiner rimaru Unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): physician and s the burial-transit The law requires that the death certificate be executed Exam resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical anding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 4 Z<del>Unkn</del>own 1 ∏ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an s certificate has t lirector, page 2 s 1 ☐ Yes 2 4 NO or Attanding Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Sharsing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ Ho 1 Inpatient 2 EN/Outpatient 3 DOA this s after death.
I Director: After this of in by the funeral d 27. Manner of Beath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 UNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 🗋 Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H0054424 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , 20 E. Timonium rd. #209 Timonium, MD 21093 Asadi 31. Date filed (Month, Day, Year) 🥭 gistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUN 0 8 2006